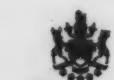
PRE-SERVICE ORIENTATION

Family Care Home Program

Participant Resources



BRITISH COLUMBIA

Ministry of Children and Family Development

102-03366/

Module 1

Introduction to Fostering

Participant Resources

MCF 203

Module 1:
Introduction to Fostering

Participant Resources and Handouts

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The Family Care Home Program 1-1

Through its Family Care Home program, the ministry provides family-based care for children in care (under ministry care, custody or guardianship) as well as supports for foster parents. The ministry works closely with the B.C. Federation of Foster Parent Associations (BCFFPA) to create programs and services that work best for children in care and for the people who look after them.

Foster homes provide substitute parenting for children who cannot safely stay with their own families, whose families have asked for help with parenting during times of crisis, or whose families need specific or periodic help in caring for their children. In the foster home, the child receives:

- physical care such as clothing, food and shelter
- emotional care, including love and inclusion in a family
- nurturing of both intellectual and emotional development
- guidance and supervision
- positive role modelling

The Family Care Home program is based on four important ideas:

- **Professional volunteer parenting**. Foster parents are people with important skills and experience related to caring for children. Not everyone has the skills or personality needed to be a foster parent.
- **Inclusiveness and teamwork**. Foster parents, ministry staff, children in care and their parents, and other community helpers are all necessary partners in carrying out the program. The relationship among the partners isn't always easy, and each case is different, but teamwork is essential to the process of helping children.
- **Graduated levels of care**. Different children have different needs, ranging from reasonably straightforward to very complex. These needs can only be met by a range of foster parents with various levels of skill, and types of experience and training.
- **Child's Comprehensive Plan of Care**. The care for each child is based on a plan created by each child's service team, including the family care parent, which specifies who will be doing what, when it will occur and the expected change that is to happen.

The overall goal of the Family Care Home program is to provide family-based care for children which nurtures, heals and develops their potential.

Source: *The Foster Family Handbook*, Second edition, Ministry for Children and Families

Types of Family Care Homes 1-2

There are five kinds of Family Care Homes: restricted, regular, and three levels of specialized homes. Each has its own type of Family Care Home agreement with the ministry.

- **Restricted** homes care for children known or related to the foster parents. The agreement is restricted to a specific child and ends when the child leaves the home or is no longer in care.
- **Regular** homes represent the greatest number of foster homes. Children placed in these homes are not usually known by the foster parents.
- **Specialized** homes (levels 1, 2 and 3) care for children with moderately to extremely challenging behavioural/emotional issues or significant developmental delay. Each level has specific approval, experience and training requirements, and separate service expectations.

All foster parents receive a per-diem (per day) payment for each day a child is placed with them. Specialized family care parents also receive a service payment that recognizes their extra responsibilities and service expectations and which also includes funds for monthly relief.

Types of Care

Family Care Homes may provide one or more of the following:

- **Short-term or temporary care**. Most foster care is given while a solution is being found for the conditions that led to the placement of the child. The intent at the time of placement is to return the child to the family. Depending on the progress of the care plan, short-term or temporary care can be as short as one day but usually is not longer than 24 months.
- **Long-term care**. This is for a child who is in continuing care by court order, through the *Family Relations Act* (orphaned without a guardian) or under the terms of a Special Needs agreement.
- **Emergency care**. The home takes the child with very little advance notice (same day or less than 24 hours). Placement might be during usual working hours or, for those homes that are willing, late in the evening. The home is generally used while another placement is researched and found. An emergency placement lasts up to 14 days.
- **Respite care** provides a short break for parents while the child is cared for in another home. These homes provide short-term care on an intermittent basis, taking children for a day or a few days at a time (for example, two days a week or four days a month). Note that a child is not legally "in care" in this situation. Respite is given to the child's parents as a family-support service, governed by a Support Services agreement between the child's parents and the ministry. In these cases, the child's parents retain full custody and guardianship.
- **Relief care** is similar to respite, except that the break is provided for foster parents. Some family care homes are established to provide relief for other ministry caregivers. Specific rates are set for this service, irrespective of the designated level of the home receiving the relief.

Agreements with the ministry

In British Columbia, all foster homes operate under a Family Care Home agreement. You sign the agreement after your home has been approved. **Only then can children be placed in your home**. Agreements are contracts and, as such, are legally binding on both the foster parent and the ministry.

Just as there are different types of Family Care Homes, there are different types of agreements under the Family Care Home program:

- **Restricted Family Care Home agreements** may be signed for up to one year and must be renewed each year. The maximum number of children per home is six, including the foster parent's own children.

- **Regular Family Care Home agreements** may be for up to three years. The maximum number of children per home is six, including the foster parent's own.

- **Specialized Family Care level 1 agreements** may be signed for up to three years. The maximum number of children per home is six, including the foster parent's own.

- **Specialized Family Care levels 2 and 3 agreements** may be for up to 18 months. The maximum number of children placed in a home is three for level 2, and two for level 3. The maximum number of children in a home is six, including the foster parent's own.

  Agreements in levels 2 and 3 may be child-specific or bed-specific.
  - Child-specific agreements purchase one placement for a specific child. When the child leaves the home, the agreement is terminated, unless the plan is to use the bed for another child within 30 days of the discharge of the original child.
  - Bed-specific agreements can be made if a home is going to be used on a regular, ongoing basis, and not for a particular child.

- **Respite and Relief agreements** are used for short stays away from the child's regular home. Respite care provides the child with a brief planned stay away from their family home and is arranged through a Support Services agreement. When Family Care Homes provide relief for other foster parents, the service is called "relief."

The Family Care Rate Explained 1-3

Foster parents receive payments at rates developed to reflect the actual costs of caring for children. The ministry issues cheques for family care homes by the 15th of each following month. This means, for example, that if a child were fostered in the month of August, the cheque for that period would arrive close to the middle of September.

The Family Care Rate

The Family Care Rate covers the regular ongoing costs of raising a child. All Foster Family Care Homes receive the Family Care Rate. Level 1, Level 2 and Level 3 Foster Family Care Homes receive a service payment in addition to the Family Care Rate.

You are expected to budget the Family Care Rate over the year and across placements. The rate reimburses you for the following:

- **food** - the child's share of food purchases including food prepared in the home, brought in or eaten out, school lunches and baby formula;
- **household** - the child's share of the household costs including, but not limited to, bedding, linen, household supplies and utilities as well as to provide for the increase in the normal wear and tear of furniture and soft furnishings resulting from additional children in the home;
- **transportation** - the child's share of family transportation costs including, but not limited to, day-to-day transportation costs which are specific to or on behalf of the child and as outlined in the child's plan of care. This includes transportation to school, to medical appointments, to recreational activities, to visit local family, and the cost of a bus pass;
- **health, personal care, supplies for young children** - the child's personal care costs (haircuts, shampoo, toothpaste, tooth brushes, personal hygiene) and car seats, diapers, and other supplies for young children;
- **family recreational outings** - the child's share of the cost of family outings;
- **clothing** - the direct costs for the child's replacement clothing and clothing repairs;
- **equipment** - the costs of equipment for basic care (e.g., beds, cribs) as well as for sports, recreation, and hobbies;
- **personal allowance** - a spending allowance intended solely for the child's personal use; in-home services - cost of care of natural children and the child-in-care while the parent is away from home on child-in-care related business (school interviews, agency conferences and local Foster Parent Association meetings) or for caregiver outings;
- **gifts and activities** - the cost of gifts for the child's birthday and Christmas, and for the costs relating to participation in ongoing activities related to the child's creative,

cultural and physical development. For example: Cub, Scout and Brownie uniforms, registration fees and tuition fees for music, arts and crafts, swimming lessons, participation in sports activities and camp fees. (The difference between the per diem camp fee and the Foster Family Care rate may be paid as a "One-Time Only payment");

- **education** - all primary and secondary school related costs. For example: costs related to physical education classes, driver's education course fees, other course fees, school supplies, locks, locker fees, field trips; and other costs directly related to caring for a child.

Foster Family Care Homes Payment Tables

Foster Family Care Rates Effective January 1, 2001

Level of Care Provided	Maintenance Payment	Service Payment	Family Care Rate
Restricted/Regular Care			
age 11 and under	$701.55		$701.55
age 12–19	$805.68		$805.68
Specialized Care			
Level 1			
age 11 and under	$701.55	$358.02	$1,059.57
age 12–19	$805.68	$358.02	$1,163.70
Level 2			
age 11 and under	$701.55	$1040.40	$1,741.95
age 12–19	$805.68	$1040.40	$1,846.08
Level 3			
age 11 and under	$701.55	$1716.66	$2,418.21
age 12–19	$805.68	$1716.66	$2,522.34

Steps to Becoming a Family Care Home 1-4

The following are the required steps in becoming an approved Family Care Home in British Columbia.

Pre-Service Foster Parent Orientation – All prospective family care home parents are required to complete eighteen hours of Pre-service Foster Parent Orientation.

Application – Prospective family care home parents must complete the Application to Provide Restricted/Regular Family Care. The application asks for **three** references to support the application to provide care for children. One reference must be a relative or a member of your extended family.

Medical Assessment – Applicants are given a Foster Home Application medical report form for completion by their physician. (The ministry is responsible for payment of the physician's fee for completing the medical report).

Ministry Criminal Record Check – All applicants undergo a Ministry Criminal Record Check and will be reimbursed the fee charged by the local police agency. In addition, anyone over eighteen years of age who is or will be residing in the family care home must undergo a criminal record check. In addition, a criminal record self-disclosure is also required.

Criminal Records Review Act – This provincial legislation requires every person who works with children to undergo a criminal records review with an authorization form. This is separate from the ministry's criminal record check procedure.

Foster Family Assessment – After the child's worker has received your application and the above required documentation has been completed, the child's worker will telephone and arrange an appointment for home visits with all household members of the prospective family care family.

Family Care Home Contract – If the references, criminal record check, medical report and foster family assessment are satisfactory and the home is approved for placement of children in care, a Family Care Home contract is signed with the Director and a copy is given to the caregiver(s).

Custody and Guardianship 1-5

Implications for Foster Parents

Who can make decisions and what decisions can be made when a child is in care varies considerably depending on how custody is set out in an agreement or a court order. Custody and guardianship do not mean the same thing.

- Guardianship includes all the rights and responsibilities of a parent, including making legal decisions about the child. This would include, for example, consent to medical care, to a driver's licence, to marriage or to out-of-country travel.
- Custody includes the day-to-day care of the child and includes some or all of the guardianship roles and rights of a parent.

I. Through Agreement between the Director and the Parent:

Formal arrangement	Overall Goal	Guardianship Status	Implications for Foster Parents
Respite (Support services agreement)	Remain in home through temporary supports	Child's parent or guardian retains both custody and guardianship	Child is not "in care." Parents retain planning and work closely with foster parents. Ministry contributes money and supports only.
Voluntary Care agreement	Return home	Child's parent or guardian	Parents have access to the child and generally retain decision-making rights over various aspects of the child's life, such as education, religion, and medical care (except emergency).
Special Needs agreement	Return home or independence	Child's parent or guardian	Parents have access to the child and generally retain decision-making rights over various aspects of the child's life, such as education, religion, and medical care (except emergency).

II. Through Court Action Undertaken by the Director:

Formal arrangement	Overall Goal	Guardianship Status	Implications for Foster Parents
Supervision order	Monitoring child's safety and well-being	Child's parent or guardian	Not in foster care. Resides with parent. This order can be made at the end of a child's time in foster care.
Interim custody order	Return home	Child's parent or guardian (director has care of the child)	Parents may have access, and retain right to all but emergency guardianship decisions.
Temporary custody order	Return home	Director (except right to consent to adoption)	Parents may have access, and should be consulted on most decisions. Seek clarification from child's worker.
Continuing custody order	Adoption (if under age 12), placement with extended family or aboriginal community, continuing foster care, independence.	Director	Director is sole guardian. Parents may apply for access.
Family Relations Act, section 29 (Legal guardian dies without will).	Temporary care until more appropriate Plan of Care is established	Director	Director is sole guardian. Preferred plan is placement with extended family.
Adoption Act	Adoption	Director	Temporary care while adoptive home is found.

The Child, Family and Community Service Act 1-6

The *Child, Family and Community Service Act* (1996) is the provincial legislation that provides the legal authority for child welfare services in British Columbia, including foster care. Everything we do for children and youth in care (and therefore everything done in the Family Care Home program) is authorized by and consistent with this act. This includes the *Standards for Foster Homes* which must be administered and interpreted within the context of this act.

The following four sections of the *Child, Family and Community Service Act* are of particular importance for foster parents.

- Guiding Principles (section 2)
- Service Delivery Principles (section 3)
- Best Interests of Child (section 4)
- Rights of Children in Care (section 70)

Guiding Principles

The Guiding Principles form the basis for practice and decision-making under the act. They reflect society's values regarding children and families. **It is important to note that this section of the act directs that the safety and well-being of children are the paramount considerations in all decisions and actions taken under the act.**

Guiding Principles (section 2)

a) children are entitled to be protected from abuse, neglect and harm or threat of harm;

b) a family is the preferred environment for the care and upbringing of children and the responsibility for the protection of children rests primarily with the parents;

c) if, with available support services, a family can provide a safe and nurturing environment for a child, support services should be provided;

d) the child's views should be taken into account when decisions relating to a child are made;

e) kinship ties and a child's attachment to the extended family should be preserved if possible;

f) the cultural identity of aboriginal children should be preserved; and

g) decisions relating to children should be made and implemented in a timely manner.

Service Delivery Principles

The Service Delivery Principles define the manner in which all services offered through the act are to be delivered. These principles govern the work of ministry staff, including child workers, **but also apply to foster parents**. Basically, these principles stress that:

- the child, the natural family and – in the case of aboriginal children – the community all have continuing roles in decisions about the child's care
- any service provided must respect the cultural, racial and religious background of the child
- communities should, when appropriate, be involved in caring for children

Service delivery principles (section 3)

The following principles apply to the provision of services under this act:

a) families and children should be informed of the services available to them and encouraged to participate in decisions that affect them;

b) aboriginal people should be involved in the planning and delivery of services to aboriginal families and their children;

c) services should be planned and provided in ways that are sensitive to the needs and the cultural, racial and religious heritage of those receiving the services;

d) services should be integrated, wherever possible and appropriate, with services provided by other ministries and community agencies;

e) the community should be involved, wherever possible and appropriate, in the planning and delivery of services, including preventive and support services to families and children.

Best Interests of the Child

Since a child's best interests can mean different things to different people, this section explains the term in detail. It lists seven factors that must be considered when a child's best interests are being determined.

In the case of aboriginal children, the act underlines the relation of their aboriginal heritage to their best interests. In practical terms, this means finding ways to maintain children's connection to their aboriginal communities when they come into care, including a preference for placements with extended family, if this reinforces the other factors that make up their best interests.

Best Interests of the Child (section 4)

1. Where there is reference in this act to the best interests of a child, all relevant factors must be considered in:

   a) the child's safety;

   b) the child's physical and emotional needs and level of development;

   c) the importance of continuity in the child's care;

   d) the quality of the relationship the child has with a parent or other person and the effect of maintaining that relationship

   e) the child's cultural, racial, linguistic and religious heritage;

   f) the child's views;

   g) the effect on the child if there is delay in making a decision.

2. If the child is an aboriginal child, the importance of preserving the child's cultural identity must be considered in determining the child's best interests.

Rights of Children in Care (section 70)

What the Act Says	What this Means for Foster Parents
• To be fed, clothed and nurtured according to community standards and to be given the same quality of care as other children in the placement.	Children in care are entitled to the same care (food, clothing, shelter, medical and dental care, nurturing and so forth) that members of the community would find acceptable for their own children. All children in care living in the same home must receive similar treatment, so long as it fits with their Plan of Care. It is important to remember that quality of care must not depend on behaviour or be subject to favouritism.
• To be informed about their Plans of Care. • To be consulted and to express their views, according to their abilities, about significant decisions affecting them.	Foster parents help children to understand what is in their Plan of Care, encourage them to express their views about these plans, and ask their opinions whenever important decisions are taken. Foster parents and the children's social workers must tell children what will happen to them while they are in care, and must listen to the children's views on the matter.
• To be given reasonable privacy and to have possession of their personal belongings. • To privacy during discussions with members of their families, subject to subsection (2).	Children in care are entitled to privacy, and to keep their personal belongings. The act uses the word "reasonable," recognizing that there might be occasions when limiting these rights is appropriate. For instance, the child's right to speak privately with members of their family may be limited by a court order. Or these rights may not apply under circumstances of threat to the safety or well-being of the child or other person. For example, a child may hoard food in their room to the point that it becomes a health hazard. Any such limitation, however, must be made in a way that still respects the child. This means that such decisions should usually be made openly, with the child given the opportunity to express an opinion on the matter.
• To be free from corporal punishment.	Foster parents must not subject children in their care to any use of physical force, such as spanking, hitting or slapping, that may inflict pain. This is an absolute right, with no exceptions.
• To be informed of the standard of behaviour expected by their caregivers and of the consequences of not meeting their caregivers' expectations.	Children must know what behaviour is expected of them, what the rules of the house are, and what will happen if they break these rules.

What the Act Says	What this Means for Foster Parents
• To receive medical and dental care when required. • To participate in social and recreational activities if available and according to their abilities and interests. • To receive the religious instruction and to participate in the religious activities of their choice. • To receive guidance and encouragement to maintain their cultural heritage.	The foster parent's role in carrying out the rights listed at left is described in each child's Plan of Care (which is created with input from the foster parent). Be alert for emotional as well as physical signs that a child may need help. It could be that they are excessively sad or depressed, or having an unusually hard time adapting to being in care. It's important for children to have friends and to be involved in activities. Speak to the child's social worker if you need help finding out what's offered in your community. Remember that the child may not be comfortable with any religion. That's their choice, too. If you don't have the background or knowledge to help the child preserve their cultural ties, ask their social worker to help you locate others who can.
• To be provided with an interpreter if language or disability is a barrier to consulting with them on decisions affecting their custody care.	The degree of consultation in all cases will depend on the child's development and ability to understand. If children have problems understanding the language used in the home, or have disabilities that are barriers to speaking or understanding, they have a right to assistance (through interpreters or augmentative communication aids) to help them communicate about important matters. The child's social worker can help you obtain interpretive services.
• To privacy during discussions with a lawyer, the Child, Youth and Family Advocate, the Ombudsman, and member of the Legislative Assembly or a member of Parliament. • To be informed about and to be assisted in contacting the Child, Youth and Family Advocate. • To be informed of their rights under this act and the procedures available for enforcing their rights.	Foster parents and the children's social worker must tell children what their rights are. This includes being informed about what the Child, Youth and Family Advocate can do for them and how to contact the Advocate if they wish to. The foster parent or child's social worker can also contact the Advocate on behalf of the child.
• A child who is removed under Part 3 is entitled to exercise the right in subsection (1)(l), subject to any court order made after the court has had an opportunity to consider the question of access to the child.	When a child who has been removed from their home because of a protection concern the foster parent ensures that the child has privacy when meeting with members of their family unless the court orders otherwise. Consult with the child's social worker for clarification.
• Section 70 does not apply to a child who is in a place of confinement.	The rights of children in care are not enforceable when the child is detained in a mental health or correctional facility.

Themes and Learning Objectives for the Six Modules

Module	Learning Objective
Module 1 – Introduction to Fostering	To orient participants to the program, facilitators and each other, especially focusing on the values and expectations of the participants in relation to ministry expectations.
Module 2 – The Needs of Children Who Come Into Care	1. To ensure participants have a realistic appreciation of the needs of children who come into foster care; 2. to equip participants to respond to the impacts of abuse and neglect on children.
Module 3 – Attachment, Separation and Loss	To introduce the concept of attachment, and to explore its importance in relation to maintaining family relationships while children are in foster care.
Module 4 – The Team Approach to Caring for Children	To ensure participants understand the ministry's team approach and their key role within it using the presence of an experienced foster parent to bring direct and recent experience to the discussion.
Module 5 – Positive Caregiving and Styles of Parenting	To introduce participants to the core elements of positive caregiving, highlighting the difference between punishment and effective discipline, and the impact of parenting styles on children in foster care.
Module 6 – Preparing for Placement	To ensure that participants have access to all necessary information: to assist them in making the decision to foster; for receiving a child into foster care; and for accessing ongoing support as required.

Case Study - Lynda

At age 13, Lynda came into care by court order following a disclosure of sexual abuse by her father. Prior to her disclosure her friends had thought of Lynda as a girl who had everything; nice clothes, lots of possessions, lessons in anything that she was interested in, a nice house, and two parents. She seemed good at everything and popular with everyone.

However, she told a friend's mother that her own mother was not interested in anything she did; in fact, she was so involved in her own career she hardly talked to her. She started crying when she said bitterly that she thought she was more her Dad's wife than his daughter. When questioned about what she meant she described a pattern of slowly increasing sexual involvement with her father over the years culminating in sexual intercourse over the previous weekend.

She described her father as always having been affectionate with her. It was he who tucked her into bed, read stories to her, comforted her when she had had bad dreams and who lay with her when she was upset. Over the years his touch had very slowly graduated from non-sexual to sexual, from stroking her hair to stroking her genitals. Lynda loves her father and his attention but has become confused and troubled by her feelings.

In the foster home, Lynda has tried hard to participate in family activities but is often quiet and withdrawn. She has confided to the foster mother that she just wants to go back home and try to make up to her parents for the pain and upset that she has caused.

Case Study Questions – Lynda

1. How would you, personally, react ***emotionally*** if Lynda were placed with your family? How would other members of your family react?

2. If you have other children in your home, would you think it appropriate for them to be told about Lynda's abuse? Please explain the reasons behind your response.

3. Do you believe Lynda's ***father*** should have access to Lynda for visits? Please explain the reasons behind your response.

4. Do you believe Lynda's ***mother*** should have access to Lynda for visits? Please explain the reasons behind your response.

5. What needs do you think Lynda would have? How could these needs be met by your family in your home?

Case Study - Kai

Kai is a one-year-old child who is in the permanent care of the Ministry for Children and Families by court order. The ministry's plan for Kai, once his medical needs are stabilized, is adoption.

There has been no contact with his mother since she left the hospital after his birth. Kai's mother was addicted to cocaine by the time she was 16. She had her first child at 17. The child was born suffering from the effects of her addiction and was removed from her and placed on a restricted foster home basis with her mother (the child's grandmother). Her second child, Kai, was born when she was 18 and it appeared her drug use had more profoundly affected this child. He was diagnosed as having Neonatal Abstinence Syndrome, a condition in which the infant suffers withdrawal from narcotics after birth.

His very distinctive high-pitched cry, hypersensitivity to sound and light, and feeding difficulties kept him in hospital for three months before he was released to a foster home. In the foster home he gradually settled in and the hypersensitivity to light and sound had all but faded away by seven months. It was hoped that the long-term effects of his mother's addiction would be minimal. However, the very high-pitched, persistent cry remains.

He has very recently been diagnosed with severe hearing loss. It is thought that the high-pitched cry is one of the few sounds he can hear which is why he cries so constantly – a challenge for the foster mother who is also trying to learn sign language to teach him to communicate.

Case Study Questions – Kai

1. How would you, personally, react *emotionally* if Kai were placed with your family when he was first released from the hospital? How would other members of your family react? Who would find his crying most difficult? Who would tolerate his crying best? What support would you draw on? What support could the Ministry for Children and Families provide?

2. Do you believe Kai's mother should have access to Kai for visits? If yes, how often? If no, why not? Please explain the reasons behind your views.

3. Do you think your home would be a suitable placement for Kai: a) when he first came out of hospital? b) Now, 7 months later? Please explain the reasons behind your views.

4. What needs do you think Kai would have? How could these needs be met by your family in your home?

Quiz on Legislation and the Foster Family Care Home Program

While most citizens of British Columbia are familiar with the existence of foster care and foster children, much less is known about the formal aspects of the Foster Family Care Home Program and how it operates. As a way of opening up discussion on these issues, please take a few minutes to respond to the following questions. Where you are not certain of the answer, please make your best guess. This is not for a grade, and you will not be asked to reveal your score to anyone else!

Please indicate whether you think each of the following statements is True or False.

1. The Foster Family Care Home Program is purely an informal arrangement between foster parents and families in the community, and anyone who wants to can be a foster parent. True False

2. In foster care, the best interests of the child's family is the most important consideration. True False

3. Once a child comes into care, the community is not involved in the planning or delivery of services to the child. True False

4. Children in foster care have the right to participate in the religious activities of their choice, and they do not have to participate in the foster family's choice of religious activities if they don't want to. True False

5. Like all parents, foster parents have the right to spank foster children if they misbehave. True False

6. Once a child comes into foster care, it is the responsibility of the foster family to decide what care and services the child is to receive. True False

7. A child's own views and opinions should be taken into account when decisions are being made that concern the child. True False

8. The Standards for Foster Homes are guidelines only, and foster parents do not have to follow any of the standards that do not seem reasonable to them. True False

9. The *Foster Care Act of British Columbia* (1996) governs all of the functions of the Foster Family Care Home Program in B.C. True False

10. Most foster children remain in care until they are 19 years old and do not return to their parents. True False

Module 1 Take-Home Sheet
The Rights of Children and Youth in Care

Children and youth in care have specific rights that must be honoured and actively promoted by everyone working with children and youth in care, including ministry workers and caregivers. The active participation of young people enhances their sense of belonging within the foster family home and encourages them to become self-determining adults in future years.

Please discuss the following questions with members of your family and briefly record any questions or comments they may have. At the next Orientation session, we will discuss the comments and seek to answer any questions your family may have.

1. Children in care should be given the same quality of care as other children, including the foster parents' children, in the foster home. Do you foresee any potential difficulties in putting this expectation into practice within your family situation?

   _____
   _____
   _____
   _____

2. Children in care must be consulted and invited to express their views about significant decisions affecting them. Which of the following decisions do you consider significant? (Please indicate response with a check mark.)

	Significant	*Not significant*
a) bed time		
b) room decoration		
c) school attended		
d) brand of shampoo/soap		
e) whether to visit a parent		

   Please give an example of a decision affecting the child that you would *not* want to consult the child on?

   _____
   _____
   _____
   _____

3. A child in care has the right to be free from corporal (physical) punishment. Do you ever use physical punishment with your own children? If yes, do you see this as potentially causing any problems? How might you deal with this issue?

   _____
   _____
   _____
   _____

Evaluation of Module 1

In order to assist the facilitators in planning and structuring future training sessions, we welcome your comments and suggestions. This form should only take a few minutes to complete. Thank you.

Please rate how well the session helped you to attain the following objectives.

1. I feel at ease with the other participants and the facilitator.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

2. I feel that my perspectives and questions are acknowledged and welcomed.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

3. I think the six sessions will be relevant and helpful in making my decision to foster.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

4. This session helped me to think about my personal and family values, beliefs and assumptions about being a foster family.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

5. I have an understanding of the philosophy, purpose and expectations of the Family Care Home Program.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

6. I am aware of the legislation governing the foster care program in B.C. and of the rights of children in care.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Comments?

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_____

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Module 2

The Needs of Children Who Come into Care

Participant Resources

Module 2:
The Needs of Children Who Come into Care

Participant Resources and Handouts

2-1 Some of the Reasons Children and Youth Come into Care

2-2 Children in Care (Provincial Statistics and Profile)

2-3 Child and Youth Development

2-4 Understanding the Concept of "Development"

2-5 Child Development and Milestone Reference Chart

2-6 Changing Needs of Growing Children

2-7 Defining Child Abuse and Neglect

2-8 Shaken Baby Syndrome

2-9 Some Possible Effects of Abuse and/or Neglect on Children and Youth

2-10 Recognizing Indicators of Possible Child Abuse and Neglect

2-11 When a Child Discloses Abuse or Neglect

2-12 Reporting Child Abuse or Neglect

Handout: 2:1 Take-Home Sheet: Assessing Readiness to Foster
Evaluation of Module 2

Some of the Reasons Children and Youth Come into Care

2-1

Neglect
A family does not look after a child or youth's basic needs such as food, clothing, shelter, health and cleanliness. Neglect also applies to a family that does not supervise the child or youth, prevent injury, or give proper medical attention and the chance to get an adequate education.

Emotional Abuse
A family does not give the child or youth the emotional care and support necessary for normal growth and development. This can include withholding affection, using threats, or any other parental behaviour which damages the child or youth's dignity and self-worth.

Physical Abuse
A family hurts a child or youth physically or allows the child to be hurt by a parent, caretaker, sibling or other person.

Sexual Abuse
The child has been, or is likely to be sexual abused or exploited by a member of the child's family or another person.

Abandonment
The child has been abandoned and adequate provision has not been made for the child's care.

Voluntary Agreement
Children or youth are placed into care voluntarily by agreement with the parents or guardians because they are temporarily unable to look after the child in their home, for a variety of reasons.

Special Needs
Parents may be unable to provide care in the home to a child who has specific needs that require individualized or specialized care and support services. Special needs of the child may include ongoing behavioural, developmental, physical, mental or emotional conditions.

Unable or Unwilling to Provide Care
The child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care.

Custodian/Guardian Deceased
If the parent who has custody and guardianship of the child dies and no adequate arrangements have been made the ministry assumes guardianship under the *Family Relations Act.*

Adoption Consents Signed
If a parent signs adoption consents and places a child for adoption through the ministry and there is no immediate placement available, the ministry may take responsibility for the child until an adoption placement.

Children in Care (Provincial Statistics — December 2001) 2-2

Legal Authority for Care

- 85% of children are in care by legal order under the *Child, Family and Community Service Act*
- 11% of children are by voluntary care or special need agreement under the *Child, Family and Community Service Act*
- 2% of children are in care of the Director under the *Family Relations Act*
- 1% of children are in care of the Director under the *Adoption Act*

Number of Children in Care

- 9,659* children were in care as of December 31, 2001
- 38% of children in care are of Aboriginal heritage

Some Primary Reasons for Children Coming into Care

- 34% — parents unable or unwilling to care for child
- 19% — neglect by parent with physical harm
- 9% — emotionally harmed by parent
- 8% — physically harmed by parent
- 5% — child has a behavioural condition parents could not manage
- 4% — abandoned without adequate provision for their care

Gender of Children in Care

Age	0–4 years	5–9 years	10–14 years	15–18 years
Female	48%	45%	45%	49%
Male	52%	55%	55%	51%

Provincially 47% of children in care are female, and 53% of children in care are male.

Children in Care by Age Group

0–4 years	5–9 years	10–14 years	15–18 years
17%	22%	30%	31%

* Does not include children in care placed through delegated Aboriginal agencies.

Placement of Children in Care

- 62% of children in care are in Family Care Homes.
- 23% are in Contracted Specialized Residential Settings (i.e., group homes or staffed residential resources).
- 15% either live independently supported by the ministry, are in adoption homes, with relatives, other government resources, or do not choose to live in approved ministry placements.

Source: The Ministry for Children and Families — Data Analysis Branch
CF&CS Statistics/December 2001

Child and Youth Development 2-3

What is 'Child and Youth Development'?

The term "child and youth development" refers to certain patterns of growth which commonly occur. These basic patterns are identifiable and predictable for all people.

What are the Domains of Development?

There are five basic domains of development: physical, intellectual, social, emotional and sexual. These domains are interconnected and at times, it is difficult to separate the development in one from the development in another.

Physical development includes muscle development and the use of muscles. It also includes the development of organs, tissues and the senses. A large part of physical development is the sensory integration component, or the brain's ability to interpret signals the body is receiving and to determine a plan of action.

Intellectual development includes thinking, memory and problem solving. Sometimes this area is referred to as the cognitive or mental domain.

Emotional development refers to the affective or "feeling" part of the individual. It includes one's expression of emotions, the ability to recognize feelings and to act appropriately in a variety of different situations.

Social development includes how individuals relate to others, and how they enter into social relationships. It is an expression of how the person meets their needs of belonging and closeness to others.

Sexual development - we usually think of sexual development as occurring in adolescence but it begins in infancy and most people reach sexual maturity in their mid/late teens.

Understanding the Concept of "Development" 2-4

Although there are many theories of child development and differing conceptions of it, there are several principles that are agreed upon by most developmentalists.

1. Development is an **ongoing** process
   - begins with conception and ends with death
   - is ontogenetic - it begins with development of a fertilized egg
   - occurs throughout life, not just in childhood

2. Development is a **dynamic** process
   - it involves continuous change, which is often called growth
   - without change, we have no development

3. Development is **directional**
   - most developmental processes evolve in predictable, defined directions
   - from simple to complex (i.e., gross motor development in infancy) to coordinated complex movements of an athlete in adult life

4. Development may involve **stages**
   - at predictable times in the developmental process, particular tasks emerge; these points or plateaus are "stages"
   - development can be qualitative in the emergence of a trait that has no precursors, such as stranger anxiety
   - stages may build upon each other

5. Development is **cumulative**
   - early developmental tasks form the foundation for the development of later, more complicated tasks. This is critical in understanding the importance of early recognition and intervention when children are developmentally delayed.
   - negative effects of early deficits increase as the child grows

Variables affecting the outcome of development are divided into two major categories: heredity, or genetic predisposition, and environment. Most people will agree that development is shaped by the interaction of both. Whatever the content of these experiences, it is useful to think in terms of every child "moving through" a number of loosely sequential developmental stages.

It is important to remember that stages are not discrete entities with clear boundaries. Stages grow into and evolve from one another. Also, while there are large numbers of tasks appropriate to be learned within each stage, not all of the tasks of any stage are likely to be learned before the child passes through to the next stage.

Source: Ministry for Children and Families Child Protection Social Work Training Program: Child Development, December 1997

Child Development and Milestone Reference Chart 2-5

Note: The age groupings and numerical values throughout this reference chart are based on average outcomes and not intended to be absolute.

Stage	Physical and Sexual	Cognitive	Social	Emotional
Infant 0 - 1yr	• Control and mastery over one's own body in both gross and fine motor skills • A sensual being who experiences pleasure from touch to all parts of the body • Boys experience erections and girls produce lubrication in their vagina from birth onwards The following milestones and infant behaviours are highlights of the first year, and are by no means totally inclusive.	• Cognition begins with alertness, awareness, recognition, and interest in visual, auditory, and tactile stimuli. As motor development improves, the infant begins to explore and manipulate objects and develops a basic understanding of their properties.	• Attachment to primary caregiver	• The development of basic trust, which follows from a positive attachment between the infant and the primary caretaker. Occurs during the first year. This is key to healthy emotional development.
Newborn - 1 month	• Weight: 2.5 - 4.3 kg (5.5 - 9.5 lb) at birth • Will lose up to 10% of birth weight in the first week and then gain it back by the second week • Weight gain averages about 20 gm/day (3/4 oz) for the first 5 months • Sleep as much as 20 hours/day • Feeds 6 to 12 times in 24 hours • Sensory capacities present are smelling, tasting, hearing, touching, temperature differences, perception of pain, and basic vision. For the first 2 months the infant is able to focus on large objects within 33 cm (13 in.) • Body stiffens when picked up • Strong grasp reflex present • Moves arms and legs and kicks when crying • Will turn head but is unable to lift or hold it • NAS produces irritability to lethargy	• Stares at human faces and moving objects • Neonatal Abstinence Syndrome (NAS) produces a short attention span	• Finds comfort in cuddling and skin to skin contact • Neonatal Abstinence Syndrome (NAS) produces insecure attachment	
2 months	• Will lift head when laying on abdomen • Follows a moving light • Has discovered hands			• Smiles at people and stimulating activities

Stage	Physical and Sexual	Cognitive	Social	Emotional
3 - 6 months	• At 3 months will hold up head, control eyes and follow moving objects • At 4 months will lift up onto arms when laying on abdomen, roll from abdomen to back, can sit when propped • Will bring hands together in play and reach out to grasp a toy • Between four to six months, infant will roll over from back to abdomen and gain full control over neck and head motions • By 6 months, will hold a rattle securely and pass it from one hand to the other • Starting at 6 months the infant will sit momentarily with legs spread apart • Will double birth weight by about the 5th month and continue to gain about 15g/day (1/2 oz.) for the remainder of the first year • Baby teeth may start to appear between 5 to nine months	• Explores and manipulates objects • Verbalizes intentionally by cooing and then babbling by 6 months	• Demands and loves attention, especially with primary caregiver(s)	• Has a variety of facial expressions which vary from those of being content, grumpy, angry uncertain and at times expressions are not always reliable indicators for the first 2 months • Giggles at 5 to 6 months
7 - 10 months	• By 8 to 9 months the infant will sit independently and move from a sitting position to laying on the floor and back again • Getting closer to 10 months the infant will creep/crawl and pull themself to a standing position	• Develops object permanence - the belief that an object exists even when it is out of sight • Imitates speech sounds	• Stranger anxiety and separation anxiety occurs	• Expresses stronger feelings of affection, anger, frustration and jealousy
11 - 12 months	• Able to walk around or in between furniture while holding onto it • May walk independently by 12 months or not until 16 months • Will triple birth weight by the end of the first year and have grown 1 1/2 times their birth length	• Begins to understand language and may say up to 10 words, e.g., mama, dada, cookie	• Is most comfortable around and likes to show off to people who are well known	• Starts to feel the emotion of guilt when a parent express disapproval

Stage	Physical and Sexual	Cognitive	Social	Emotional
1 - 2 yrs	• During the second year the toddler perfects gross and fine motor skills that emerged during the first year by developing balance, co-ordination, stability, and an improved ability to manipulate objects • Naturally explore their own body parts, including genitals • Will begin to touch genitals for pleasure • Identify themself as a boy or girl at about the age of 15 months	• Emergence of symbolic thought • Able to understand more language and communicates with 2-word sentences at 18 - 24 months	• Develops affectionate and trusting relationships with other family members and with adults outside the family • The child can also play and engage in simple games	• Development of autonomy. This includes mastery and control over themself and their environment
2 - 3 yrs	• Develops increased strength and uses motor skills to master challenges in the environment, such as bicycles, stairs, balls, playground equipment, eating utensils, crayons and other objects. The child is developmentally ready to master toilet training. Note: It is important to remember that some cultures view the dependence to independence time frame differently. Children in some cultures are not expected to eat, bathe, dress independently until significantly later than the milestones identified here. • Identifies with parent of the same sex to develop a male or female identity • Begins to develop an attitude toward their own body • Exploratory masturbation and sex play occur	• Major growth in language development, by 3 years old the child will have a vocabulary of about 300 words and speak in 3- to 5-word sentences	• Forms rudimentary relationships with other children • Parallel play; play in the presence of, rather than interaction with, other child • Imitate social roles • Toilet training	• Development of autonomy • Develop a basic self concept, experience pride and pleasure at being "good" and embarrassment, shame and distress at being "bad"
	• Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effect (FAE), Neonatal Abstinence Syndrome (NAS) produce central nervous system hyperactivity, over-sensitivity to stimuli and irritability	• Fetal Alcohol Syndrome/Fetal Alcohol Effect create difficulty with memory, information processing comprehension, language	• Fetal Alcohol Syndrome produces over-trusting behaviours and need for structure	

Stage	Physical and Sexual	Cognitive	Social	Emotional
3 - 5 yrs	• Most basic gross motor abilities have emerged, skills are practised and perfected, and increased mastery of motor skills to increasingly challenging and complex situations • Curious about genitals (their own and others) • Masturbates - erotic stimulation from the genitals becomes more intense • Engages in sex play • Establishes a firm identity as being male or female • Enjoys bathroom humor • May mimic adult sexual activities • Curious about their origin and where babies come from • Improved self-care skills	• Language develops rapidly • Grammar and syntax are refined, and vocabulary increased geometrically - the child uses language as a communication tool • Concrete thinking • Egocentric thinking • Magical thinking and fantasy are prevalent	• Social relations with adults outside family expand • Interactive and co-operative play with peers • Explores, imitates and practises social roles • Distinguishes right from wrong • Understands rules • Experiences guilt for wrong doings	• Development of initiative. The preschool child has been described as "on the make" • Self-directed • Takes charge • Intrusive • Manipulates environment • Curious, tries new things • Assesses self • Self-esteem emerges
6 - 8 yrs	• Practises, refines, masters complex gross and fine motor and perceptual motor skills, e.g., bike riding, skate-boarding, play piano • Affected by cultural values, e.g., non-active culture at school and TV results in "unit" children • Engages in masturbation and sex play • Continues to take part in bathroom humor • More curious about body functions and pregnancy: how does the baby get in and out of the mother? • Some children become modest at this age while others are still comfortable to walk about nude • Strong friendships and close peer groups consisting of the same sex • Demonstrate a strong interest in stereotypical male/female roles • Roles expectations are influenced by external resources due to increased socialization, the media and ability to read • Actively engaged in teasing and name calling	• Concrete operational thinking • Growth of logical and rational thought	• Relationships outside the family increase in importance • Friendships and peer groups develop	• Industrious, purposeful, goal-directed • Developing self-esteem

Stage	Physical and Sexual	Cognitive	Social	Emotional
9 - 12 yrs	• Continues to practise, refine and master complex gross and fine motor and perceptual motor skills • More modest and want privacy • Feel somewhat insecure about their body image and will often ask the question: Am I normal? • Curious about everything and takes part in name calling and teasing, which is often focused on body image • Experiences puberty changes: - Start at 8 to 13 years for girls, with a duration of 3 - 5 years - Start at 9 to 14 years for boys and lasts 4 - 6 years • Initial stages of puberty involve: - Rapid growth spurt for 2 to 3 years, especially for girls in this age group - Girls: hips and thighs widen, waist seems smaller - Initial growth of pubic and axilla hair - Skin and hair become oilier - Hair grows thicker and darker on legs and arms - Sweat smells stronger - Initial breast development for girls - Initial growth and maturation of external genitals - Increase of food intake and need of sleep - Mood swings and sexual feelings - Boys: larynx starts to grow larger, they become more muscular - The average age for a girl to start menses is 12 1/2	• Understand others' perspectives • Enjoys language as a communications tool • Considers others' roles in discussions • Conversations are mutual • Cognitive ability allows more effective coping skill	• Learn age-appropriate and gender-specific social roles • Broader understanding of rules, guides, social relationships and activities	• Confident and self-directed • Developing a better sense of themself as an individual, with likes and dislikes and special areas of skill • Capable of introspection • Evaluates self-worth by the ability to perform • Self-esteem based on perceived abilities

Stage	Physical and Sexual	Cognitive	Social	Emotional
13 - 14 yrs	• Continues to experience puberty changes • Girls growth in height continues until about age 14 or for a year or two after menarche • Girls breasts, external genitals and internal sex organs continue to develop and mature following the onset of menses and throughout adolescence • Boys' growth spurt most often occurs at the age of 13 -14 • External genitals for boys continue to mature and testicles start to make sperm • Boys start to grow facial hair and in general more body hair • Increased anxiety about body image and uncertainty of body changes • Maturity of sexual organs and secondary sex characteristics • May experiment in sexual behaviours will the same or opposite sex • May become sexually active • Body image affected by emotional response to maltreatment • Eating disorders can emerge • May struggle with sexual orientation	• Formal operational thinking emerges	EARLY: • Social relations centre on peer group • Parents distanced • Has greater need for privacy • Tests to see what they can get away with • Group values guide behaviour (dress, language, demeanor) • Most peer relations are same-sex • Interested in sexual relations but most contact is through groups (hanging out) • Social roles defined by external sources	EARLY: • Identity is a central development task; experiences intense feelings and wonders "Who am I?" • Tries different roles and daydreams • Depends on peers for emotional support and to mold emerging identify • Peer acceptance affects self-esteem • Emotionally labile, mood swings, vulnerable to stress
15 - 17 yrs	• Experience the end of puberty changes with maturity of sexual organs and secondary sex characteristics • More readily accepts body image with the exception of girls being concerned about fat and boys concerned about muscle • Sexual orientation is determined • May be sexually active	• Formal operational thinking becomes well developed in some cases. Includes thinking that is: - hypothetical - logical - about thinking - insightful - systematic	LATER • Values become individualized after careful consideration • Friends selected on personal character • Peer group declines in importance • 1 to1 dating • Explores social roles and careers	LATER • Identity is internal and individualized • Sense of self is separate from family and peer group • Self-esteem influenced by ability to live up to internalized standard • Self-assessment and introspection common

Source: Adapted from the Ministry for Children and Families, Child Protection Workers Training Program – Child Development Module

Changing Needs of Growing Children 2-6

Age	Child's Need	Parent's Tasks	Abusive Parenting	Effect of Abuse	Healing Care
0 - 6 mos Being Stage	• Be. Live! • Belong • Trust • Need to know they can communicate needs	• Provide physical care • Delight in child • Respond to cries • Touch, hold, stimulate, protect and nurture • Be consistent, predictable	• Being absent • Ignoring cries, needs • Hovering, "smothering" • Spanking, pinching, screaming • Withhold child support	• Excessive crying • Lack of self-worth • Sleep disturbances • Self-destructive behaviour • Lack of facial expressions • Eating disorders surfacing later	• Maintain consistent care schedule • Be more responsive • Give unconditional nurture • Give lots of physical affection • Identify and name needs
6 - 18 mos Doing Stage	• Do • Explore sensations • Try/check it out • Explore environment • Separate self from "other"	• Offer unconditional love • Baby-proof house • Provide safe toys • Care for self • Give many "yeses" • Interact and play with child	• Confining child to crib • Force feeding • Beginning toilet training • Expecting too much • Failing to supervise • Instilling fear, intimidation • Yelling, screaming	• Anxiety, inconsolable crying • Withdrawal • Fear of adults/authority • Fear of new places • Lack of mobility • Limited language development • School phobia surfacing later	• Have realistic expectations • Use sensory awareness play • Distinguish feelings (mad/sad/scared) • Insist on checking out fears • Give consistent encouragement
18 mos - 3 yrs Thinking Stage	• Separate from parent • Say "no"! • Think • Learn to choose • Speak out	• Be the "grown-up" • Provide limited choices • Honour the need to say "no" • Be in charge of the rules • Demonstrate problem-solving • Begin toilet training	• Being inconsistent • Expecting too much • Using physical punishment, • Spanking • Failing to set limits • Shaming child • Using child to obtain information about other parent	• Demanding behaviour • Out-of-control behaviour—hitting, biting, frequent tantrums • Being over-adaptive to adults/people-pleasing • Passivity • Manipulative behaviour • Addictive disorders surfacing later	• Distinguish angry feelings • Teach non-violent expression of anger • Use logical consequences • Teach child to think of others • Insist on verbal requests

Age	Child's Need	Parent's Tasks	Abusive Parenting	Effect of Abuse	Healing Care
4 - 6 yrs Identity and Power Stage	• Separate real from pretend, learn differences between feelings, thoughts and behaviour • Take action, initiate, develop sexual identity, solve problems	• Allow child to make some choices • Teach respect of own and opposite sex • Teach how to get affection • Separate child's reality from child's fantasy • Read to and talk with child	• Scaring /teasing to control • Punishing for masturbation or sexual exploration • Blaming child for parents' feelings • "Sexualizing" child • Using violence toward other parent	• Sexual shame • Excessive fears • Extreme separation anxiety, bedwetting, nightmares • Being over-adaptive/ people-pleasing • Adopting victim or perpetrator status • Aggression	• Permit child to ask for needs to be met • Permit physical affection • Confront mythical/"fairy-tale" thinking • Discuss fears • Offer comfort and assurance
7- 12 yrs Problem-solver stage	• Learn "I am able" • Form relationships outside of family • Set limits on self • Develop own rules about life	• Permit arguing and negotiating • Insist on responsibility and completion of tasks • Support friendships • Support activities outside of family • Talk about value	• Controlling access to friends, other parent, relatives • Making rules too rigid or too lax	• Inability to form relationships • Anxiety about abilities • Lying, cheating, stealing • Extreme rebellion • Headaches, stomachaches, ulcers • Early interest in sexual activity • Problems in school, truancy • Aggression	• Permit child to disagree • Permit child to not tolerate abuse • Require follow-through, responsibility • Allow natural consequences • Clarify values • Encourage interests • Use logical consequences
13 - 18 yrs Identify Sexuality, Separation Stage	• Become independent • Act on own behalf • Structure time • Accept and love self • Express mature love	• Be available but not controlling • Allow child to separate • Give information and protection on sexual activities • Allow child to experience consequences • Teach living skills	• Discounting nurturing needs • Sexualizing child's feelings, choices • Using teen for money, sex or emotional support • Teasing about body changes • Giving repeated negative messages	• Depression/ suicide attempts • Sexual assault offenses • Running away to deal with problems • Lack of internal controls, promiscuity • Headaches, stomachaches, ulcers • Chemical use • Delinquency	• Permit child to be both close and separate • Accept need for autonomy and promote experiences • Accept child unconditionally, behaviour conditionally • Provide counselling/ treatment • Provide counselling/ treatment when needed

Age	Child's Need	Parent's Tasks	Abusive Parenting	Effect of Abuse	Healing Care
Every Stage	• Feel unconditional love • Receive health care for developing body • Explore world and learn • Receive predictable emotional support • Increase self-reliance • Be respected • Experience success	• Play with children • Meet physical survival needs • Give warmth and affection • Read to/talk with children • Provide consistent limits • Assure safe environment • Seek information and personal support from other parents	• Failing to respond • Failing to supervise • Using violence/causing bodily harm • Making sexual genital contact • Spanking, pinching, name-calling • Ridiculing • Being violent to other parent, pets, property	• Difficulty trusting others • Difficulty maintaining relationships • Lack of self-esteem, self-worth • Addictive disorders • Depression • Delinquency	• Be consistent and involved • Affirm feelings • Show physical affection • Listen to fears • Encourage growth in developmental stages • Teach responsibility

Source: The information for this chart was compiled from several sources, including Brenda M. Shaeffer (1977, 1989), Constance E. Abbot (1986) and Jean Illsley Clarke (1986)

Defining Child Abuse and Neglect 2-7

Understanding what child abuse and neglect are and knowing how to take appropriate action are critical in ensuring the safety and well-being of children. The following definitions will help you respond to child abuse and neglect.

Child
A person under 19 years of age (i.e., a person who is considered a child under the *Child, Family and Community Service Act).*

Physical abuse
A deliberate, non-accidental physical assault or action by an adult or significantly older or more powerful child that results or is likely to result in physical harm to a child. It includes the use of unreasonable force to discipline a child or to prevent a child from harming him/herself or others. The injuries sustained by the child may vary in severity and range from minor bruising, burns, welts or bite marks to major fractures of the bones or skull, and, in its most extreme form, the death of a child. Physical assault is a crime.

Sexual abuse
Sexual abuse generally means any sexual use of a child by an adult or a significantly older or more powerful child. There are many criminal offences related to sexual activity involving children. The *Criminal Code* prohibits:

- any sexual activity between an adult and a child under the age of 14 – a child under 14 is incapable in law of consenting to sexual activity (s. 150.1 of the *Criminal Code).* The criminal law recognizes that consensual "peer sex" is not an offence in the following situation: if one child is between 12 and 14 years and the other is 12 years or more but under the age 16, less than two years older, and not in a position of trust or authority to the other.
- any sexual activity between an adult in a position of trust or authority toward a child between the ages of 14 and 18 years
- any sexual activity without the consent of a child of any age (depending on the activity, non-consensual sexual activity may constitute the criminal offence of sexual assault).
- use of children in prostitution and pornography.

The Ministry for Children and Families states that sexual abuse is any behaviour of a sexual nature toward a child, including one or more of the following:

- touching or invitation to touch for sexual purposes, or intercourse (vaginal or anal)
- menacing or threatening sexual acts, obscene gestures, obscene communications or stalking
- sexual references to the child's body or behaviour by words or gestures
- requests that the child expose their body for sexual purposes
- deliberate exposure of the child to sexual activity or material.

The Ministry for Children and Families states sexual exploitation includes permitting, encouraging or requiring a child to engage in:

- conduct of a sexual nature for the stimulation, gratification, profit or self-interest of another person who is in a position of trust or authority, or with whom the child is in a relationship of dependency
- prostitution
- production of material of a pornographic nature.

Sexual aspects of organized or ritual abuse should be considered a form of sexual exploitation.

Sexual activity between children or youth may constitute sexual abuse if the difference in age or power between the children is so significant that the older or more powerful child is clearly taking sexual advantage of the younger or less powerful child. This would exclude consensual, developmentally appropriate sexual activity between children where there is no significant difference in age or power between children.

Emotional abuse

Emotional abuse is the most difficult type of abuse to define and recognize. It may range from habitual humiliation of the child to withholding life-sustaining nurturing. It can include acts or omissions by those responsible for the care of a child or others in contact with a child, that are likely to have serious negative emotional impacts. Emotional abuse may occur separately from, or along with, other forms of abuse and neglect.

Emotional abuse can include a pattern of:

- scapegoating
- rejection
- verbal attacks on the child
- threats
- insults
- humiliation.

Emotional harm

When emotional abuse is persistent and chronic, it can result in emotional damage to the child. A child is defined by the *Child, Family and Community Service Act* as emotionally harmed if they demonstrate severe:

- anxiety
- depression
- withdrawal, or
- self-destructive or aggressive behaviour.

If a child is emotionally harmed by the parent's conduct, as demonstrated by these severe behaviours, the child is in need of protection. This must be reported to a child protection worker.

Neglect

Neglect involves an act of omission on the part of the parent or guardian that results or is likely to result in physical harm to the child. It generally refers to situations in which a child has been, or is likely to be physically harmed through action or inaction by those responsible for the care of the child. This may include failure to provide food, shelter, basic health care, or supervision and protection from risks, to the extent that the child's physical health, development or safety is harmed or is likely to be harmed. This also includes failure to thrive. Not always intentional, neglect may be a result of insufficient resources or other circumstances beyond a person's control.

The *Child, Family and Community Service Act* states that a child needs protection if the child has been, or is likely to be, physically harmed due to neglect by the child's parent.

Failing to provide the necessities, abandoning a child and corrupting a child are crimes.

Source: The B.C. Handbook for Action on Child Abuse and Neglect

Shaken Baby Syndrome Background Information

2-8

(Ron Ensom, M.S.W., C.S.W., Children's Hospital of Eastern Ontario

Name: Shaken baby syndrome (or SBS) is a serious neurological injury – damage to a child's brain – which is usually accompanied by bleeding behind the eyes and sometimes by other injuries. The damage to the brain is the result of a child's head being whiplashed back and forth by a violent shaking, and sometimes by the head also being forcefully struck against something. Because a baby's head is large and heavy relative to its body, and its neck still weak, whiplashing creates powerful forces inside the head. Violent shaking repeatedly squashes the brain against the skull causing bleeding from torn blood vessels, extensive damage of tissues, and life-threatening swelling of the brain.

Consequences: The degree of injury to the brain depends primarily on the forcefulness of the shaking and the child's size. If the initial injuries to the brain are severe, the child will very quickly develop alarming symptoms such as a seizure, stopping breathing and losing consciousness. Even with prompt medical care, more than one in five victims will die. Most who survive severe brain injury will have permanent disabilities such as paralysis, blindness, profound developmental delay, and seizures. Some will live in a vegetative state. If the initial injuries to the brain are less severe, children are still likely to have permanent consequences such as movement and co-ordination problems, intellectual impairment, learning problems, and seizures. Experience to date suggests that all children who survive a severe shaking injury to their brain will require special care for their lifetime. Even those less severely injured will need special services as they grow into adulthood.

SBS is Child Abuse: Shaken Baby Syndrome is child abuse – it is the consequence of an assault. It is not the result of prudent play, clumsy handling or a competent attempt to revive a baby who has stopped breathing. To inflict SBS, the shaking must be so forceful that any normal adult who happens to witness it would immediately recognize that the child will be hurt.

Prevalence: Fortunately, not all babies who are shaken are injured. No hard statistics are available yet on the number who are shaken compared to the number who sustain SBS injuries. Most professionals believe that many children are shaken than are actually injured seriously enough to show symptoms for which parents and caregivers seek medical attention.

Victims: Because the likelihood of brain injury decreases with a child's size, it is not surprising that more infants than toddlers are victims of SBS. Over 50% of all victims are under six months of age. SBS injuries have been inflicted on infants who are just days old and on children three and even four years old. Boys are at greater risk for being shaken and injured than are girls – close to 60% of victims are boys.

Perpetrators: About three quarters of SBS victims are injured by males. Fathers account for between one third and one half, and mothers' boyfriends for about 20%. Caregivers and babysitters injure between 10% and 20% of victims. Most perpetrators are under 25 years of age.

Why do people shake babies? There is no single answer to this crucial question, but we know two key things about violence and stress: 1) violent reactions are usually triggered by stress, 2) adults who injure people tend to have more violent reactions and poorer impulse controls. We know quite a bit about the stresses which trigger baby shaking. The most common "foreground" stress is a baby's persistent crying; the "background" stresses are usually an adult's exhaustion and frustration. Toileting and feeding problems are also common triggers. Less is known about the personalities of adults who shake babies. They seem to fall into two general groups: apparently normal people who are "pushed over the edge" by exhaustion and the frustration of coping with an inconsolable baby, and those who already have violent reactions to situations and people.

Preventing Shaken Baby Syndrome

- **Never shake a baby for any reason!**
- If a baby's crying, refusal to eat or resistance to a diaper change is really frustrating you, ask someone reliable to quickly take over for you. If you can't find someone on the spur of the moment, make sure that nothing obvious is wrong with the baby. Put the child in a safe place such as a crib, and walk away from the room for a while – you need a break.
- Before a baby's crying pushes you too far, check out the possibility that the crying is a sign of a particular problem like hunger, being too hot or cold, a fever, needing a diaper change, or being pinched by something.
- If you worry that you might hurt your baby, speak to a professional. Call your doctor, public or community health nurse, midwife, a qualified counsellor, a children's services provider, or a community crisis line.
- If your baby cries a lot, it may be due to a condition called "colic." Consult your doctor and organize a plan for coping with your child's demands. Set up a team of reliable family, friends or neighbours who are willing to give you regular babysitting relief or come quickly if you call. If you don't have reliable help available, or don't want to ask for it, ask a professional for advice.
- Caring for a baby is very demanding. Every parent and caregiver needs relief. Adequate sleep, a change of scene and activity, and the chance to share thoughts and feelings are necessary. Make sure that you are getting support from someone you can rely on.
- Know your caregiver. Never leave a baby with someone you don't trust or whose references you haven't checked. Never leave a child with someone known to have violent reactions.

For help or information on shaken baby injuries, contact the Helpline for Children (call the operator and ask for Zenith 1234), your family doctor, a hospital, or your local health unit or health department.

Some Possible Effects of Abuse or Neglect on Children and Youth

2-9

Affects their normal development patterns

- may find it hard to form positive relationships with other including peers
- may be sexually sophisticated beyond their years
- may be unable to do well in school, may have learning disabilities
- may be emotionally depressed, anxious, fearful
- may have speech disorders
- may have stunted growth
- may be depressed and in despair

Affects their behaviour

- can be extremely aggressive, withdrawn or overly compliant
- may be sexually active with self, toys, other children
- may avoid contact with adults
- may have irregular patterns of eating and sleeping
- may be self-destructive

Affects their feelings, moods, self-image

- may feel guilty
- may feel afraid
- may experience depression
- may have low self-esteem
- may carry around repressed anger and rage

Recognizing Indicators of Possible Child Abuse or Neglect 2-10

Anyone who provides service to children should watch for signs of possible abuse or neglect. While many indicators, particularly those of a behavioural nature, may be signs of other problems, a series or cluster of indicators observed over a period of time may be cause for concern regarding abuse or neglect. These signs or indicators often happen in combinations or as dramatic changes from normal behaviour. They may be the child's reaction to abuse or neglect, and can be a way of communicating that he or she has been, or is being, abused or neglected.

By themselves, these signs do not prove abuse or neglect. But they do tell us we need to know more about the child's circumstances.

Possible Indicators of Physical Abuse

Physical Indicators	Behavioural Indicators
• injuries (bruises, welts, cuts, burns, bite marks, fractures, etc.) that are not consistent with the explanation offered (e.g., extensive bruising to one area) • presence of several injuries (3+) that are in various stages of healing • repeated injuries over a period of time • injuries that form a shape or pattern that may look like the object used to make the injury (e.g., buckle, hand, iron, teeth, cigarette burns) • facial injuries in infants and pre-school children (e.g., cuts, bruises, sores, etc.) • injuries not consistent with the child's age and development • bald patches on child's head where hair may have been torn out • repeated poisoning and/or accidents	• runaway attempts and fear of going home • stilted conversation, vacant stares or frozen watchfulness, no attempt to seek comfort when hurt • describes self as bad and deserving to be punished • cannot recall how injuries occurred, or offers an inconsistent explanation • wary of adults or reluctant to go home • often absent from school/child care • may flinch if touched unexpectedly • extremely aggressive or withdrawn • displays indiscriminate affection-seeking behaviour • abusive behaviour and language in play • overly compliant and/or eager to please • poor sleeping patterns, fear of the dark, frequent nightmares • sad, cries frequently • drug/alcohol misuse • depression • poor memory and concentration • suicide attempts

Possible Indicators of Sexual Abuse

Physical Indicators	Behavioural Indicators
• fatigue due to sleep disturbances • sudden weight change • cuts or sores made by the child on the arm (self-mutilation) • recurring physical ailments • difficulty in walking or sitting • unusual or excessive itching in the genital or anal area due to infection(s) • torn, stained or bloody underwear • sexually transmitted disease(s) • pregnancy • injuries to the mouth, genital or anal areas (e.g., bruising, swelling, sores, infection)	**In a younger child** • sad, cries often, unduly anxious • short attention span • inserts objects into the vagina or rectum • changes or loss of appetite • sleep disturbances, nightmares • excessively dependent • fear of home or a specific place, excessive fear of men or women, lacks trust in others • age-inappropriate sexual acts • age-inappropriate sexually explicit drawings and/or descriptions • bizarre, sophisticated or unusual sexual knowledge • reverts to bedwetting/soiling • dramatic behavioural changes, sudden non-participation in activities • poor peer relationships, self-image • overall poor self-care **In an older child** • sudden lack of interest in friends or activities • fearful or startled response to touching • overwhelming interest in sexual activities • hostility toward authority figures • fire setting • need for constant companionship • regressive communication patterns (e.g., speaking childishly) • academic difficulties or performance suddenly deteriorates • truancy and/or running away from home • wears provocative clothing or wears layers of clothing to hide bruises (e.g., keeps jacket on in class) • recurrent physical complaints that are without physiological basis (e.g., abdominal pains, headache, nausea) • lacks trust in others • unable to "have fun" with others • suicide attempts • drug/alcohol misuse • poor personal hygiene • promiscuity • sexual acting out in a variety of ways

Possible Indicators of Emotional Abuse

Physical Indicators	Behavioural Indicators
• bedwetting and/or diarrhea • frequent psychosomatic complaints, headaches, nausea, abdominal pains	• mental or emotional development lags • behaviours inappropriate for age • fear of failure, overly high standards, reluctance to play • fears consequences of actions, often leading to lying • extreme withdrawal or aggressiveness, mood swings • overly compliant, too well-mannered • excessive neatness and cleanliness • extreme attention-seeking behaviours • poor peer relationships • severe depression, may be suicidal • runaway attempts • violence is a subject for art or writing • complaints of social isolation • forbidden contact with other children

Possible Indicators of Neglect

Physical Indicators	Behavioural Indicators
• abandonment • lack of shelter • unattended medical and dental needs • consistent lack of supervision • ingestion of cleaning fluids, medicines, etc. • consistent hunger • inappropriate dress for weather conditions • poor hygiene • persistent conditions (e.g., scabies, head lice, diaper rash or other skin disorders) • developmental delays (e.g., language, weight) • irregular or non-attendance at school or child care • not registered in school • not attending school	• depression • poor impulse control • demands constant attention and affection • lack of parental participation and interest • delinquency • misuse of alcohol/drugs • regularly displays fatigue or listlessness, falls asleep in class • steals food, or begs for food from classmates • reports that no caregiver is at home • frequently absent or tardy • self-destructive • drops out of school (adolescent) • takes over adult caring role (of parent) • lacks trust in others, unpredictable • plans only for the moment

Possible Indicators of Failure to Thrive

Physical Indicators	Behavioural Indicators
• a child who has stopped growing and/or has experienced significant weight loss may be suffering from failure-to-thrive syndrome. Medical assessment is necessary to determine whether the syndrome is organic or non-organic in origin • the following physical characteristics are often present in failure-to-thrive children: - child appears pale, emaciated, has "sunken cheeks" - child's body fat ratio is extremely low (e.g., wrinkled buttocks) - skin may feel like parchment paper as a result of dehydration - prolonged vomiting and/or diarrhea • child has not attained significant developmental milestones within their age range (e.g., cannot hold head up at six months of age, cannot walk at 18 months, etc.)	• appears lethargic and undemanding (e.g., cries very little) • uninterested in environment or surroundings • displays little or no movement (e.g., lies in crib motionless) • is unresponsive to stimulation from strangers • shows little strangers anxiety (e.g., indifferent to attention received from strangers)

When a Child Discloses Abuse or Neglect 2-11

1. Stay calm and listen.
2. Go slowly.
3. Reassure them that they have not done anything wrong.
4. Be supportive.
5. Gather essential facts.
6. Tell the child what will happen next.
7. Report.
8. Make notes.

1. **Stay calm and listen.**
   An abused or neglected child needs to know that you are calm and available to help him/her. Reactions of shock, outrage, or fear may inhibit the child and make him/her feel more anxious or ashamed. A calm response not only allows the child to tell his/her story, it also provides the reassurance that what has happened is not so bad that it cannot be talked about and worked through calmly.

2. **Go slowly.**
   It is normal to feel inadequate or unsure about what to do or say when a child tells you about his/her abuse. As a result, there is a tendency to rush things. Frequently, too much is asked too quickly. Proceed slowly. Gentle questions such as: "Can you tell me more about what happened?" are helpful. Avoid questions that begin with "why."

3. **Reassure the child that they have not done anything wrong.**
   Any questions that are asked are usually associated in the child's mind with getting into trouble. Avoid using "why" questions. For example: "Why did he/she hit you?" suggests indirectly that the child may have done something wrong and increases the child's reluctance to discuss the matter.

4. **Be supportive.**
   Children need support and reassurance when discussing their abuse or neglect. It is helpful to let the child know that:

   - they are not in trouble
   - they are safe with you
   - you are glad that they have chosen to tell you about this
   - they have done the right thing telling about this
   - you are sorry that they have been hurt or that this has happened to them
   - you will do everything you can to make sure they are not hurt again, and
   - you know others who can be trusted to help solve this problem.

5. **Get only the essential facts.**
   If this is the first time the child has disclosed abuse or neglect, a full investigation will be necessary. The child will be interviewed in depth by a child protection worker and, if there is a criminal investigation, by the police. To avoid the child having to endure multiple interviews, limit your discussion to finding out generally what took place. When you have sufficient information and reason to believe that abuse and/or neglect has occurred, gently stop gathering facts and be supportive.

6. **Tell the child what will happen next.**
   Children who disclose their abuse feel anxious and vulnerable about what people think of them and what will happen next. It is important, however, to avoid making promises to the child about what may or may not happen next. For example, avoid promises that the alleged perpetrator won't get into trouble. Provide only reassurance that is realistic and achievable. Discuss with the child what you think will happen next and who will be involved.

7. **Report to the child protection worker.**
   Report disclosures of abuse or neglect immediately to a child protection worker for follow-up and investigation. Express your willingness to help the child through the steps which will follow, if appropriate.

8. **Make notes.**
   Make notes of all comments made by the child about abuse or neglect using the child's exact words where possible. Save all drawings and artwork. This information needs to be shared with the child protection worker, the police and Crown counsel, if appropriate.

Reporting Child Abuse or Neglect 2-12

If you have reason to believe a child has been, or is likely to be, abused, neglected or in need of protection, you must report the matter immediately to the child's worker or child protection worker.

Legal Duty to Report

Everyone who has a reason to believe that a child has been or is likely to be physically harmed, sexually abused or sexually exploited, or needs protection due to the specific circumstances outlined in the *Child, Family and Community Service Act,* is legally responsible under section 14 of the Act to report the matter to a child protection worker.

The duty to report applies to everyone, including service providers, family members and the general public – in short, anyone who is aware of circumstances that should be reported.

- It doesn't matter if you believe someone else is reporting the situation, you still have to report.
- It doesn't matter if you're aware that a child protection worker is already involved with the child, you still have to report the matter. All new incidents must be reported as well.
- The legal duty to report overrides any duty of confidentiality, except a solicitor-client relationship.
- Time is of the essence in ensuring the safety and well-being of children. Report immediately.
- If you have reason to believe that a child has been, or is likely to be, abused or neglected, then the responsibility for making a report to a child protection worker legally rests with you.
- Do not contact the alleged perpetrator. This is the responsibility of the police or the child protection worker.
- If an employer needs to contact the alleged perpetrator in order to protect children under their authority, this should be coordinated with the police and child protection worker.

When to Report that a Child Needs Protection

The *Child, Family and Community Service Act* sets out the circumstances under which you must report – that is, when you have reason to believe that a child "has been, or is likely to be, physically harmed, sexually abused or sexually exploited by a parent or by another person and the parent is unwilling or unable to protect the child, or if the child has been, or is likely to be, physically harmed because of neglect by the child's parent," or if:

- the child is emotionally harmed by the parent's conduct
- the child is deprived of necessary health care
- the child's development is likely to be seriously impaired by a treatable condition and the child's parent refuses to provide or consent to treatment
- the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care
- the child is or has been absent from home in circumstances that endanger the child's safety or well-being
- the child's parent is dead and adequate provision has not been made for the child's care, and
- the child has been abandoned and adequate provision has not been made for the child's care.

How to Report

All child abuse and neglect concerns must be reported to a Ministry for Children and Families child protection worker or a First Nations child welfare agency that provides child protection services. This applies even if a report has been made to the police.

There are three ways to reach a Ministry for Children and Families child protection worker:

- **Ministry for Children and Families local district office**, Monday to Friday, 8:30 a.m. to 4:30 p.m. (listed in the blue pages of your phone book).
- **After Hours Lines** for Vancouver, North Shore, Richmond: **604-660-4927** Lower Mainland (Burnaby and Delta in the west to Maple Ridge and Langley in the east): **604-660-8180**. Anywhere else in B.C.: **1-800-663-9122**.
- **Helpline for Children** – dial 0 and ask the operator for **Zenith 1234**. This toll-free service operator 24 hours a day.

Module 2 Take-Home Sheet
Assessing Readiness to Foster

You have now had a beginning introduction to the Family Care Home Program, and you have thought about some of the situations and needs of children and youth coming into foster care. To help you assess your family's current readiness to foster, we suggest you consider the following questions with other family members. (This is only a *preliminary* self-assessment; you will have more to base this judgment on at the conclusion of all six sessions.)

1. What age range of children do you think your family could accept? Are there any values or cultural differences that your family may not be comfortable accepting?

   _____
   _____
   _____

2. Are there any behaviours or emotions that your family might not be comfortable dealing with?

   _____
   _____
   _____

3. What do you think you and your family have to offer and add to a foster child's life?

   _____
   _____
   _____

4. What are the most significant challenges for your family at this time in your family life?

   _____
   _____
   _____

5. How is each member of your family responding to these challenges?

   _____
   _____
   _____

6. Is your family at a stage in your family life where you can accommodate the challenges of bringing a foster child into your home? What might you need, or need to do, to be ready to welcome a foster child into your home?

   _____
   _____
   _____

Evaluation of Module 2

In order to assist the facilitators in planning and structuring future training sessions, we welcome your comments and suggestions. This form should only take a few minutes to complete. Thank you.

Please rate how well the session helped you to attain the following objectives.

1. I feel that I have an understanding of the reasons children come into care.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

2. I found the overview of normative development of children to be helpful.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

3. I found the discussion of the effects of abuse and neglect to be useful.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

4. I think that I will be able to recognize and respond to the effects of abuse and neglect more sensitively after this session.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

5. I am finding the process and approach in the sessions works well for me.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

6. I am looking forward to the upcoming sessions.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Comments?

_____

_____

_____

_____

Module 3

Attachment, Separation and Loss

Participant Resources

Module 3:
Attachment, Separation and Loss

Participant Resources and Handouts

3-1 Attachment in Infants and Children

3-2 Foster Home Standards: D.2 Culture and Religion
D.3 Preserving the Aboriginal Child's Unique Cultural Identity

3-3 The Grieving Process

3-4 Supporting Children Through Separation and Loss: Promoting Attachment, Continuity and Stability

3-5 Maintaining Family Connections

3-6 When Children and Their Families Visit

3-7 Life Book

Handouts 3:1 Family Experiences
3:2 Take-Home Sheet: Attachment and Fostering
Evaluation of Module 3

Attachment in Infants and Children 3-1

Attachment is an ongoing social process. As human beings we have the capacity to experience attachment and separation throughout our lives. The seeds for our ability to attach to others in healthy ways are sown in infancy.

Infants are completely dependent upon others to ensure that their basic survival needs are met – food, warmth, protection from the elements and external threats, physical comforting, stimulation, love and nurturing. In most typical family situations an infant's needs are consistently met by one or two people. Stability and continuity of care and need fulfillment builds trust. Over time, the infant develops deeper and deeper levels of attachment to these caregivers. This is the foundation for social development. Children who have developed healthy attachments are more likely to be able to build and sustain other relationships, be independent and develop conscience and self-discipline.

An infant who experiences inconsistent fulfillment of needs is unable to trust that the caregivers in their life will provide for them. Need fulfillment may be interrupted or prevented by parental incapacity, parental unavailability, situations associated with poverty, neglect, abuse, separation from primary caregivers or multiple temporary caregivers. In these situations there is no stability or continuity of care. The capacity of these infants to trust and develop deep attachment is impaired. Their subsequent social development is compromised. As children, youth or adults they may be referred to as "attachment disordered."

It is important to note that, because of our human predisposition to attach to others, even infants and children who have had very unstable or inconsistent care likely will still be 'attached' to someone. This is most often their parents, although it may be another family member or friend. The attachment may not be healthy or deep and the child may not associate it with trust and comfort, but it exists nonetheless. Even children and youth that have experienced horrific abuses and neglect often still have some degree of attachment with their parents. This suggests why many children and youth coming into care as a result of abuse or neglect feel conflict about being in care. On the one hand they feel relief that they will be now be protected from harm and be nurtured, but on the other hand they feel sadness about being separated from their parents.

Our early attachment experiences influence our capacity and ability to form other attachments as we develop and mature. Beyond infancy we typically form attachments to other family members, friends, teachers and others in our community. In young adulthood and adulthood we develop attachments through love relationships, with our children and friends.

For many children in care the process of developing attachment is a very difficult process and takes time, commitment and skill on the part of the caregivers and significant others in the child's life. Understanding the effects of impaired attachments helps us understand why children in our care may respond in the way that they do.

Culture and Religion

STANDARD D.2 Culture and Religion

Children receive guidance and encouragement to maintain their cultural heritage and to participate in the religious activities of their choice.

Commentary

Cultural heritage can be defined as the shared customs, beliefs, behaviours and traditions of a particular ethnic group. The right to receive guidance and encouragement to maintain their cultural heritage promotes the child's positive sense of belonging and personal identity. Children also have the right to freedom of religion and the right to choose whether or not to participate in religious instruction or activities.

Results for Children

D.2.1 Children confirm their cultural heritage is respected and supported.

D.2.2 Children confirm that they have opportunities to maintain their cultural heritage.

D.2.3 Children confirm that they have opportunities to choose whether or not to participate in any religious instruction or activities.

D.2.4 Children confirm that they are not discriminated against on the basis of gender, sexual orientation, physical or developmental disability, culture, ethnicity, religion or race.

Caregiver Practices

D.2.5 Within the context of the child's comprehensive plan of care, the caregiver provides the child with opportunities, guidance and encouragement to maintain their cultural identity.

D.2.6 Within the context of the child's comprehensive plan of care, the caregiver accepts the child's choice whether or not to participate in religious instruction or activities.

D.2.7 The caregiver encourages children to celebrate significant events in culturally appropriate ways.

D.2.8 The caregiver encourages and assists the child to keep records of significant events.

D.2.9 The caregiver does not promote their own culture or religion with the child unless required to do so as part of the child's comprehensive plan of care.

Source: *Standards for Foster Homes* © 1998, Ministry for Children and Families

STANDARD D.3 Preserving the Aboriginal Child's Unique Cultural Identity

Children of aboriginal heritage have their unique cultural identity preserved.

Commentary

Approximately one third of children in care in British Columbia are of aboriginal ancestry, while aboriginal people make up only 5% of the total population. *The Child, Family and Community Service Act* places a strong emphasis on respecting and safeguarding the aboriginal child's unique cultural identity and ties to family, aboriginal community and heritage. Aboriginal children develop a positive cultural identity by participating in their culture, by understanding their heritage and by learning of the experiences and achievements of persons of the same cultural background.

In addition to the requirements specified in Standard D.2, the following criteria apply to aboriginal children.

Results for Children

D.3.1 Children of aboriginal heritage confirm that their cultural identity is preserved.

D.3.2 Children of aboriginal heritage confirm that they have opportunities to maintain positive contact, involvement and participation with their aboriginal community.

Caregiver Practices

D.3.3 The caregiver assists in preserving the aboriginal child's unique cultural identity as identified in the comprehensive plan of care.

D.3.4 Within the context of the child's comprehensive plan of care, the caregiver assists the child of aboriginal heritage to maintain positive contact, involvement and participation with the aboriginal community.

Source: *Standards for Foster Homes* © 1998, Ministry for Children and Families

The Grieving Process 3-3

Grieving is a natural and necessary process in response to loss. When either adults or children experience a major loss or change in their lives, they go through a variety of strong grief feelings. Although each individual experiences such changes and feelings in their own way and at their own speed, there is enough similarity among people that we can generalize and talk about the "stages" of grief.

- **Shock and denial**
- **Anger and protest**
- **Bargaining**
- **Depression**
- **Resolution**

There are two important things to remember about these "stages." Firstly, they are not passed through step-by-step like a child through the grades of school. People may cycle back and forth between several different stages, stages may overlap, or people may regress back to early stages. They may also get 'stuck' in a particular stage and may need some help to get 'unstuck.' This is to be expected. You may have experienced these stages and these challenges yourself. Resolution of grief is a journey which requires a long time, frequent rests and some backtracking. The only way 'out' is 'through.'

When children are separated from people to whom they are attached – even if they have been abused and neglected – they will grieve. They will feel many different emotions and their behaviour and development can also be impacted. Therefore, the second point to remember is that the expression of the various feelings is the way the individual gets over a loss. That is, when children or youth are experiencing these feelings, they are starting to recover, and we should no more prevent them from feeling as they do than we should stop a scab forming over a cut. They are both ways of getting better. The grief feelings may be difficult to allow, however, partly because they remind us of our own pain.

The Five Stages in the Grieving Process (and How they Relate to Children Coming into Care)

1. Shock and denial

Characteristics:

This is sometimes called the "honeymoon" period of fostering. Children can appear to be fitting in well (for the first few days to six weeks), and not exhibit some of the problem behaviours that the child's worker may have described. The child is so numb that they are obedient, compliant and eager to please. When children are numb or deny the separation, they feel less pain.

The child may insist that a mistake has been made or may deny that the separation will continue for a long time. A child may continually ask if their parent has called or when the parent will pick them up.

Typical behaviours:

- robot-like behaviour
- limited or no emotional reaction to the move
- appear to make a good adjustment to the separation and move
- unable to pay attention to what is going on around them, distracted
- limited interest in favourite activities or such things as eating and playing
- docile, quiet and conforming.

What can Foster Parents do?

Foster parents need to be understanding of the shock that the child has suffered, and to be accepting, patient, calm and reassuring. It is important to create a sense of order, balance and private emotional and physical space for the child.

More specifically, the following strategies may help:

- Be clear about rules and responsibilities for the child.
- Encourage open communication about the child's history, expectations and fears.
- Begin or add to the child's life book. If the child has been in another placement, incorporate as much information as possible, such as pictures and mementos from this placement.

2. Anger and protest

Characteristics:

This stage is sometimes called the "testing" period. Typically children enter this stage when they have begun to feel secure in their placement. They now begin to express their anxiousness, helplessness and rage about the separation and loss of control that they have experienced. The anger and protesting is often directed at the foster parent who may be seen as responsible for the separation.

This is the stage at which the children are most likely to run away. They are typically not running "from" the foster home, but rather "to the familiar." They may be searching for what they perceive to be lost (the natural parents).

This is the stage at which the children are most likely to be rejected by the foster parents as they argue, scream, fight, destroy toys or property, cry, appeal for help and then reject it, suffer from sleeplessness, etc. Older children may turn to drugs or alcohol, or may try to set up the foster parent to behave as the natural parent did.

Children have many ways to try to make placements fail, in order to regain the familiar. If "stuck" in this stage, they can become children who keep moving from one foster home to another.

Typical behaviours:

- tantrums
- destructive behaviour
- defiance, control battles with authority figures
- aggression towards others in the home, pets, peers
- lying, stealing
- crying
- negative comparisons made between parents or previous caregivers and new foster parents.

What can Foster Parents do?

At this stage, it is essential to hang on and tough it out. It is important to understand that the behaviour is caused by rage at life in general, not intentionally aimed at the foster parents. The objective is to help the child safely and constructively express their anger and accept their feelings.

More specifically, the following strategies may help:

- Model for the child how to let anger out constructively, for example, punching a pillow or skipping rope.
- Acknowledge and alleviate the child's fears and anxieties where possible.
- Have clear, pre-set consequences for broken rules and enforce these consequences calmly and consistently in response to the child's defiance or destructiveness.
- Ensure that child has lots of opportunity for physical play and activity.
- Encourage younger children to express anger through dolls, puppets, stories, art.
- Encourage older children to express anger through verbal and written communication, journal writing.
- Reduce the risk of the child destroying things that matter to them or to the foster family; put things away until the child's anger diminishes.
- Acknowledge and alleviate the child's fears and anxieties where possible.

3. Bargaining

Characteristics:

During this phase children express their tendency for 'magical thinking' through believing that they can change their circumstances by behaving well or by cutting the right deal. Underlying this is the child's belief that they are responsible for the separation and loss.

Typical behaviours:

- eager to please and promise to improve behaviour
- ritualized behaviours, e.g., compulsive hand-washing or other 'good' behaviours
- attempts to negotiate agreements with new foster parents or worker.

What can Foster Parents do?

It is important to communicate to the child in a developmentally appropriate way that they are not responsible for the separation. They must be relieved of the burden of guilt, shame and responsibility for their situation.

More specifically, the following strategy may help:

- Talk with the child about the reasons for the separation and placement. Ensure that the child hears that they are not responsible and that the continuation of the separation is not contingent on their behaviour.

4. Depression

Characteristics:

In this stage the child realizes their powerlessness to reverse the separation and often feels overwhelming sadness, anguish, depression, hopelessness and fearfulness. They can become very inwardly directed, silently stating, "I'm no good. Who could really love me?"

The child in this stage may be apathetic, unorganized, messy with personal belongings and habits, may cry easily, and may have nightmares. They may prefer to spend time alone, and show withdrawn, self-consoling and sometimes self-destructive behaviour such as rocking back and forth, head banging, and blaming themselves for their loss. They don't know what to do, can't remember how to get to school, and find getting up and having breakfast difficult. They have little motivation to do anything.

Typical behaviours:

- social and emotional withdrawal
- regressive behaviours such as thumb-sucking, toilet accidents, baby talk
- play is mechanical, limited enthusiasm and affect
- listless, distracted, unmotivated
- poor academic performance.

What can Foster Parents do?

Paradoxically this is the first sign that things are improving and the child is getting healthier. Foster parents should give permission to the children to "feel" and "to suffer."

More specifically the following strategies may help:

- Provide emotional support and reassurance.
- Provide opportunities to share feelings of depression with the foster parent, worker, therapist or other significant and supportive adult.
- Validate and acknowledge the child's feelings.
- Share personal experiences of loss with child and empathize with their sadness.
- Give the child permission to opt out of planned activities for awhile.
- Provide factual information about the child's family and help the child make realistic future plans.
- Be specific about what will happen today and tomorrow. Be careful not to make promises you or others might not be able to keep.
- Watch older children and youths for suicidal gestures.

5. Resolution

Characteristics:

During this stage children regain a sense of hope (life goes on), a sense of mastery (I will survive), and begin to feel comfortable with themselves and others. Some of the pain has been worked through, and the children can let go and begin to look toward the future. The major grieving is over, but there may be a renewal of grieving behaviour at critical times such as the anniversary of the separation, subsequent losses, during a special event or holiday or when moving to a new developmental stage.

If the child has had healthy attachments in the past they will usually direct behaviour toward developing or strengthening new relationships within the foster family and community. Child becomes more organized, motivated and can make plans for the future.

Typical behaviours:

- develops and strengthens attachments to the foster family members
- engages in goal-directed behaviour again.

What can Foster Parents do?

- Ensure that the child's plan of care is followed or amended as necessary to promote continuity, stability and attachment in the child's life.
- Encourage the child's interests.

Supporting Children Through Separation and Loss: Promoting Attachment, Continuity and Stability 3-4

Children and youth who are separated from their parents and family will experience crisis. It is important for foster parents to remember not to make hasty judgments or conclusions about children's mental states at this time. It is only natural that separation, loss and grief would cause a disruption in normal physical, mental and emotional patterns. How can foster parents in partnership with ministry staff and the child's family respond to the separation and grieving process of children and youth?

The stress and impact can be minimized through attending to the child's need for the following:

Continuity	Stability	Attachment

Some ways in which the foster parent can support the child in their care:

- **Helping the child to understand the reasons for the placement**: The child's worker should discuss with the child, the "Who, Where, What, Why, How long, etc." of the placement. The foster parent may need to reinforce or repeat this information for the child.

- **Assisting the child to adjust to a new environment**: Familiarizing the child with the home, family and neighborhood helps to ease the child's anxiety. Consider what will be important from the child's perspective, given their developmental age and likely needs. Giving the child a tour of the home and their bedroom, discussing routines and schedules and house rules, discussing meals and availability of food, using a photo album to help the child become acquainted with family members, friends, neighbours and the community are all techniques that one can use to increase familiarity.

- **Helping the child to maintain a relationship with their family**: The child's legal status and comprehensive plan of care will guide the ways in which the foster parent supports the child's connection to family. In a day-to-day sense, it is important that the foster parent 'gives the child permission' to keep any positive connection with their family, at least in an emotional sense. This may be supported by allowing the child to talk about their family, keeping and displaying photos of family members, keeping a scrapbook of things that the child has done or been involved in that can be shared with the birth family, and working with the child on their life book.

- **Giving the child a sense of security**: Key to supporting the child to feel secure is understanding the child's experience and developing empathy for the way that the child may be viewing the placement in care and in the foster home. This helps the foster parent to determine what will help to promote continuity and stability for the child. On a day-to-day basis it may help to respect the child's attachment to certain items such as a blanket, doll, teddy, photograph, or article of clothing. It helps to continue the child's involvement in activities that they enjoy, their connection to friends and to cultural or religious activities. It may help to accommodate the child's diet, or at least introduce them to new and different meals sensitively. Security also comes from following through on commitments made to the child, such as picking them up from school on time and taking them to events as planned.

- **Helping the child maintain cultural identity**: The shock the child experiences as a result of placement will be lessened if cultural differences are minimized. This is a significant consideration for the ministry in determining where a child should be placed and as much as possible children will be placed with families of similar cultural heritage. However, it is possible that children will be placed in foster families with different cultural heritages. It is important that foster families seek to understand the child's culture and traditions and promote cultural continuity through such things as incorporating special events and holidays or traditions into the family's plans, and encouraging the child's participation in community cultural events.

Maintaining Family Connections 3-5

To help the child maintain connections with their family, the following are suggestions for caregivers:

- Maintain a positive attitude toward the child's family. Acknowledge their good qualities and their ability to change.
- Mention the child's family in your daily conversations with the child. For example, discuss visitation, when the child might return home, the current living situation of the child's parents, things the child used to enjoy doing with their parents, etc.
- Recognize the child's need to talk about their family. Encourage the child's expression of thoughts and feelings, and be interested in what the child has to say.
- On a regular basis, share information with the child's family regarding the child's daily activity, progress and growth. It is preferable to discuss such information in the presence of the child.*
- Share with the child's family pictures, reports cards, medical reports and examples of the child's school and art work.
- Make known to the child's family appointments, meetings, birthday parties and special events related to their child. Invite the child's family to attend.*
- Encourage the child to send cards and letters to their family. Help the child to do so if necessary.*
- Include the child's family in routine tasks with the child, such as visits to the doctor or shopping for clothing.*
- Ask the child's family to bring photographs to share with the child. Pictures from the child's past help bring back memories and highlight the positive moments spent with their family. Foster parents may feel better about the child's family after seeing a photo of them nurturing their child; for example, throwing a baseball with the child or giving the child a bath.
- Compliment the child's family on their accomplishments. Make your positive comments in the presence of the child.
- Identify small ways in which the child's family can make decisions for their child. For example, the child's family can be consulted concerning the child's haircuts and which of the child's personal possessions can be discarded.*

* *As outlined in the child's comprehensive plan of care and after discussion with the child's worker regarding the appropriateness of doing so. There may be legal or safety issues.*

When Children and their Families Visit 3-6

One of the best ways for children to maintain contact with their families is through home visits. Visits help children see their families realistically. Without contact, children may develop or hang on to exaggerated ideas about their families, whether positive or negative. Visits also reassure children that their families are still a part of their lives, and help them adjust to having two families now.

Whether your relationship with particular families is positive or difficult, it is important for you to be sensitive to the children's changing emotional states, to their feelings toward family relationships and to the ongoing nature of their relationships with family and kin.

The following are some possible emotions and stresses that may arise during visits, for the child, the child's family and foster parents – especially on the first few occasions.

For the Child's Family

- A feeling of guilt and shame over their failure to care for their own children.
- Anger at themselves for not being "more competent" and "in charge."
- Anger at the child as the cause of family breakdown and the visible evidence to the public that all is not well.
- Fear of condemnation and rejection by the foster parent as well as their own children.
- A sense of helplessness and dependency on others.
- All this mingled with a sense of relief that someone knows, cares and is helping and that their child is safe.
- A desire to "make up" with their child.
- A fear of what "family secrets" their child has said to you or will say to you.
- An acute awareness of the material differences between their home and lifestyle and yours.
- An acute awareness that the emotional atmosphere between homes may be different.

It is not surprising, given all of the above, that initial contacts may be tinged with hostility, anxiety, argumentativeness, critical comments and a sense of competitiveness. The child's parents on visiting may find themselves feeling "tight" and present themselves as "cold," "rigid," "unyielding" or only interested in talking with you. Inside, they are likely bursting with conflicting emotions, resulting often in overreactions or a very flat response. In fact, the parents may find the thought of the visit so stressful, they may not show up.

For the Foster Parents

- It is not uncommon for foster parents on their first meeting with the child's parents to report a sense of shock – the reality that the children have parents finally hits home.
- A sense of sadness for the children and parents.
- Anger, especially when visits do not go well.
- A desire to "protect" the children.
- Fear of a "loss" of the child they have come to love.
- Anger at the judgmental comments of the child's parents.
- A fear all the gain made by the child will be lost.
- A sense of guilt that they are "taking away" the children from their parents.
- Fear of the child's parents – "What do I do if they want to take the child with them?"
- Fear of what the children might say to their parents about the foster home.

For the Children

- A heightening of their sense of loss, grief and anger.
- A confusion of "Whom do I belong to?," "Who is in charge?," "Whom do I listen to?"
- "What can I say and to whom?" – the result is children often say nothing or parrot what they think adults want to hear. This behaviour is often interpreted as disinterest or lack of attachment on the child's part.
- The children begin to feel some guilt about caring for their foster parent.
- A sense of anger and frustration arising from their helplessness (control is in adult hands – they may feel completely "left out").
- Fear of conflicting demands.
- Confusion over promises.
- Fear of adult demands and of "doing the wrong thing."

The feelings described above are normal reactions for children and with some experience and positive results, soon seem less frightening. In fact, successful visiting often helps children settle in. If they feel their parents and their foster parents have some agreement and good feeling between them, the children will often settle in more quickly.

With the child worker's assistance, some guidelines to help visiting be a positive experience are:

- Before the child's visit, it is useful to talk to the child's worker about:
  - the location and length of the visit
  - how food and gifts will be handled; recognize that most parents want to give material things to their children – be accepting and flexible
  - how to give the child and parents some privacy if visiting in the foster home
  - some family care home agreements (particularly those for specialized care, levels 2 and 3) specify that the foster parent will supervise visits between children and their families. In other situations, the child's worker may ask a foster parent to play a particular role in visits.

  In any circumstances in which there may be some risk to anyone involved in the visit – including the child or the foster parent – it is a good idea to discuss with the child's worker who is to attend and supervise the visit. If possible, visits should be arranged for times that do not disrupt the regular activities of your family.

- Try to develop an understanding of what emotions you might have and try to put yourself in the child's parent's place – develop an understanding of their perspective of the situation.

- You may want to rehearse what to say in advance.

- Plan three things to do to cover embarrassing gaps.

- Some joint activities may help break the tension, e.g., a walk, a game, etc.

Do not be surprised if the child is a little upset after the visit – lasting from a few hours to two or three days. The upsets can range from quiet, withdrawn behaviour to "acting out." This is part of the normal grieving process. With warm support and acceptance from the foster parents, this behaviour reduces in intensity and length. If the upset behaviour continues or becomes more intense, please discuss the matter with the child's worker.

Life Book 3-7

Children and youth in care should have a Life Book which represents many important aspects of their lives from their past to their present. Every child who is likely to remain in care for more than six months has a Life Book. A Life Book is an informal record of the people and events in the child's life while they are in your care. Life Books give children a sense of personal history and continuity. It is jointly maintained by the child's worker, the child and foster parents. Foster parents will usually look after the book. When a child leaves care, the Life Book is given to them.

Here is a guide to some information that can be included in a child's Life Book:

- birth information
  - date of birth
  - length and weight
  - time of birth
  - photos
  - hospital
- information about birth parents and siblings
- developmental milestones
- information about injuries, illnesses or hospitalizations
- favourite activities
- favourite birthday and holiday gifts
- information about ways child celebrated special holidays
- favourite friends
- information about the ways the child shows their feelings
- pictures of foster family and pets
- pictures of child with foster family
- pictures of birth family during visits
- cute "naughty" behaviours
- ways the child liked to show affection
- special trips or vacations with the foster family
- information about visits with birth relatives
- letters from friends and relatives
- any special extended family member
- certificates of achievement
- names of teachers and school attended
- report cards
- classroom pictures
- school projects
- special activities, such as clubs or camping experiences
- with newborns up to four months, take pictures every few weeks if possible
- badges and ribbons
- souvenirs from trips, concerts, sporting events, cultural events and so on

Family Experiences Questionnaire

The purpose of this questionnaire is to help you to remember some of your own family experiences with family attachment and family relationships. If we can recall some of the experiences that were significant for us, positively and negatively, we can be more sensitive to the experiences of children and young people who may come into our care.

1. Can you recall an early childhood experience of feeling close to someone in your family? Think of a time when you felt safe and cared for, or surrounded by warm feelings – a really happy moment with a close relative when you were a child. Briefly note the *who*, *when*, *where* and *what* that you remember.

2. Think back to a time when you were very upset, or anxious, about being separated from a close family member. It may be a time when you were left at someone else's house, or the first day of kindergarten, or being left in the car by yourself, or going off to camp, or …? Write down a few words that describe what you were feeling.

3. At this point in your life, when you have to go away from home and loved ones for a while – say on a trip for a week or two – what do you do to keep in touch with those you miss? Do you take a photo with you, or some other memento or souvenir that reminds you of them? Do you call on the telephone? If you call, when do you call…as soon as you arrive at your destination, when you start to miss them, at a certain time of day, or…? Write down what you do, and how this makes you feel.

4. Do you have any questions about the rights of children in care and their implications for caregiving? If so, please note them on the back of this page and bring this sheet to the next Orientation session for discussion. Thank you.

Module 3 Take-Home Sheet
Attachment and Fostering

We have explored the importance of attachment in children's development, and we have recognized the need to sensitively support foster children in maintaining their family relationships while living with a foster family.

The following questions may help you to assess the potential impacts of this process on you and your family as a whole.

1. How would you feel about the child's parents or other family members visiting in your home?

2. How would your family accept a child whose cultural or racial heritage is different from yours? What would your family be able to do to assist the child to maintain their cultural identity?

3. What would you find most difficult to deal with when the child is experiencing strong feelings of grief and loss?

4. How are you likely to feel when a child in care leaves your home? What might you need to do to deal with this process?

Evaluation of Module 3

In order to assist the facilitators in planning and structuring future training sessions, we welcome your comments and suggestions. This form should only take a few minutes to complete. Thank you.

Please rate how well the session helped you to attain the following objectives.

1. I found the discussion of readiness to foster to be helpful.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

2. I feel that I have a better understanding of the experiences of separation and loss that foster children and their familes experience.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

3. I found the discussion of the nature of attachment and its importance to children coming into care and their families to be useful.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

4. I think that I have a good appreciation for the importance of supporting the family relationships of children coming into care.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

5. The session helped me to be more aware of the potential links between my own personal experiences and those of children coming into care.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

6. I am finding these sessions are helping me to better understand the realities of foster care.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Comments?

_____

_____

_____

_____

Module 4

The Team Approach to Caring for Children

Participant Resources

Module 4:
The Team Approach to Caring for Children

Participant Resources and Handouts

4-1 **The Team Approach to Guardianship**

4-2 **Roles: Who Does What?**

4-3 **Standard C-1 – Comprehensive Plan of Care**

Handouts **4:1** **Take-Home Sheet - The Role of Foster Parents**
Evaluation of Module 4

The Team Approach to Guardianship 4-1

When assuming guardianship of a child in British Columbia, whether short-term or long, the ministry becomes responsible for the all of the child's needs. **In order to ensure that the child's needs are assessed and addressed according to their best interests, ministry workers form a team with the child, the child's family, caregivers, service providers and others who the child considers to be important.** The guardianship team ensures integrated planning and delivery of services to meet the child's needs during their time in care. The child's worker is responsible for:

- the creation of a guardianship team around each child
- the creation of the child's Comprehensive Plan of Care
- ultimate decision making about how the child's needs will be met after hearing the views of the other guardianship team members.

Here are some guidelines for working together effectively as a team:

1. **Focus on the best interests of the child.**

2. Each team member **understands** one another's roles and responsibilities, and **cooperates** with other team members.

3. There is a high level of **coordination** of services.

4. Establish channels of **communication** to share essential information.

5. Each team member assumes responsibility **for maintaining the right of a child in care to privacy** and holds shared information in confidence.

6. There is shared **planning** for specific goals.

7. There is continuous **assessment** of progress toward goals.

8. Each team member **supports** the other – each team member feels important.

9. **Respect for one another**. Each member of the team brings individual viewpoints, values, culture and concerns to the team. Together the team can build the best plan for the child.

10. People **ask for help** when they need it.

Roles: Who Does What?

4-2

(adapted from: B.C. Federation of Foster Parent Associations)

Child's Worker

- Handles the legal process and placement of the child
- Is responsible for developing the child's Comprehensive Plan of Care and ongoing planning for the child, case conference, etc. in conjunction with the foster parent and the resource worker
- Is responsible for ensuring the child has their rights under the *Child, Family and Community Service Act* explained to them and are actively upheld
- Is responsible for ensuring that the child is aware of the ministry's internal complaints process and how to access the office of the Children's Commission and the Child, Youth and Family Advocate
- Provides information to foster parent about the child that pertains to the child's placement
- Supports foster parents in understanding and working with the child and child's family
- Arranges visits between the child, and the child's family. Discusses the supervision of visits if required with foster parents
- Assists the child's family
- Assists the foster family in identifying and using community resources to support the child

Resource Worker

- Recommends the child(ren) for placement
- Provides support and guidance to foster parents
- Refers foster parents to additional training and support
- Assists in clarifying placement service plans and expectations
- Assesses and recommends additional payments or supports
- Reviews the skills and capabilities of foster parents
- Assesses foster parents for specialized family care
- Assesses and reviews the caregivers' capabilities annually

Foster Parent(s)

- Cares for, nurtures and loves the child
- Provides for the child's physical, emotional and spiritual needs
- Provides appropriate supervision and discipline
- Assists child's worker in developing and reviewing comprehensive plan of care
- Carries out caregivers' responsibilities identified in comprehensive plan of care
- Helps the child develop good habits and realistic goals
- Respects the child's uniqueness, child's family and cultural heritage
- In consultation with the child's worker, assists in planning for the child as well as connecting with community resources to help the child
- Communicates and works with the child's worker
- Cooperates with the plan to assist the child's family
- Understands the importance of the child's connection to family
- Assists the child to understand their rights under the *Child, Family and Community Service Act* and actively upholds these rights

Child's Parent(s)

- Visits and assists the child in the placement process as agreed in the child's Comprehensive Plan of Care
- Identifies the issues they need assistance with, and to seek and to use this support to change the current family situation
- Meets the term of any directives or agreements given by the court
- Prepares for the return of the child(ren)
- Assists in developing a permanent plan of care for their child if appropriate

Comprehensive Plan of Care 4-3

STANDARD C. 1 Comprehensive Plan of Care

Each child or youth is entitled to have a written, individual comprehensive plan of care which has been developed in consultation with the caregiver, the child and where possible, their parents.

Commentary

The caregiver is expected to be informed about the circumstances surrounding the child and to participate in the development and reviews of the child's comprehensive plan of care. The caregiver will have certain responsibilities under the comprehensive plan of care, including keeping the child's social worker informed about developments concerning the child. Caregivers are expected to accept responsibility for only those aspects of the comprehensive plan of care that they are capable of carrying out.

Results for Children

C.1.1 Children confirm that, at or near the time of placement, the caregiver has provided an explanation for that placement based on the child's comprehensive plan of care and children confirm that they have understood the explanation.

C.1 2 Children confirm that the caregiver has encouraged and assisted them to participate within their ability in the development and reviews of their comprehensive plan of care.

C.1.3. Children confirm that the caregiver has attempted to help them understand the role of professional who work directly with them, either at home or elsewhere.

C.1.4. The caregiver advocates for and participates in the development and reviews of the child's comprehensive plan of care.

C.1.5. The caregiver encourages and assists the child to participate within their ability in the development and reviews of their comprehensive plan of care.

C.1.6. Before or at the time of placement, the caregiver will have in their records the following information (if available from the child's social worker) to ensure the safety and well-being of the child accepted into the home:

a) the child's full name, gender, birth date and legal status;
b) the circumstances leading to the placement including:
    1) family information relevant to caring for the child;
    2) cautions or restrictions on the child's activities or contacts; and
    3) the names and telephone numbers of family members or significant others, as noted in the comprehensive plan of care, who are available as supports to the child;
c) the child's known interests, abilities, strengths and presenting issues;

d) the child's physical and emotional health and any health concerns, including required medications, allergies, dietary restrictions and physical limitations;
e) the name of the child's social worker, the district office and telephone number, and the name and telephone number of the social worker or office to call in the case of an emergency;
f) the child's physician's name and telephone number and child's personal health number;
g) the name of the school or day program that the child is or has been attending; and
h) specific routine monitoring of the child as identified in the comprehensive plan of care.

C.1.7. The caregiver keeps all information about the child and family confidential. The caregiver shares information only with other persons or agencies needed to carry out the child's comprehensive plan of care, or as permitted by law.

C.1.8. In case of emergency placements or in other instances where the information outlined above is not known to the child's social worker at the time of placement, the caregiver cooperates with the child's social worker to obtain the information as soon as possible.

C.1.9. Before or at the time of placement, the caregiver discusses with the child's social worker the sleeping arrangements for the child to ensure that these arrangements meet the child's needs for adult supervision, safety, privacy and adequate sleep.

C.1.10. Before or at the time of placement the caregiver discusses with the social worker (and the child's family as authorized by the child's social worker) the following:

a) the care needs of child;
b) the steps to be taken by the caregiver and by the child's social worker to meet these needs. Immediate care needs include: emotional and physical safety, clothing, medication, continuity of school or vocational or day programs, and arrangements for impending appointments such as doctor's visits and court appearances;
c) the involvement of the child's family in matters such as visits and telephone calls, including any conditions and restrictions;
d) the involvement of any necessary support.

C.1.11 At the time of placement the caregiver, in a manner that is sensitive to the emotional state and developmental level of the child:

a) introduces the child to the other members of the household;
b) shows the child the layout of the home and their sleeping area;
c) tells the child what the household routines, expectations and rules are;
d) give the child the opportunity to ask questions and discuss their concerns;
e) attempts to help the child understand why they have been placed in the home, and
f) attempts to help the child understand the roles of professionals who work directly with them, either at home or elsewhere.

C.1.12 Following placement and on an ongoing basis, the caregiver provides the child's social worker with information about their experience with the child, including:

a) progress in the desired outcomes outlined in the comprehensive plan of care;
b) the child's current functioning in health, education, identity, family and social relationships, social presentation and emotional and behavioural development;
c) the caregiver's capacity to meet the caregiver's responsibilities under the comprehensive plan of care.

Source: *Standards for Foster Homes* © 1998, Ministry for Children and Families

The Comprehensive Plan of Care

The child's guardianship worker is responsible for ensuring:

- that a written, individualized comprehensive plan of care is in place within thirty days of the decision to bring the child into care, and
- that the plan is reviewed and updated every six months thereafter while the child is in care (or more frequently if specified in the comprehensive plan of care or if circumstances arise that make a review necessary).

The comprehensive plan of care is developed in partnership by the child's worker with the caregiver, the child and where possible the child's parent and other appropriate persons.

The comprehensive plan of care includes:

- information that identifies the child (name, date of birth)
- the overall goal for the child
- assessment of the current status of the child's:
  - health
  - education
  - identity
  - family and social relationship
  - social presentation
  - emotional and behavioural development
  - self-care skills.
- for each of the dimensions above the following is noted:
  - current functioning
  - work required
  - desired outcomes
  - person(s) responsible
  - target date
  - date completed
  - comments.
- the views and signature of the child, the caregiver, the child's social worker, the child's parent (if appropriate) and any other appropriate planning participants
- a schedule for the review of the plan.

Module 4 Take-Home Sheet
The Role of Foster Parents

These questions focus on the role you will be expected to play as a foster parent and the responsibilities that are important for ensuring that the needs and interests of children in your care are met. Please write down your reactions to these questions, and any concerns or questions needing further clarification.

1. What do you see as the advantages and disadvantages of sharing the parenting of a child with Ministry for Children and Families and the guardianship team?

   Advantages:_____
   _____
   _____

   Disadvantages:_____
   _____
   _____

2. How do you respond in group situations such as team meetings? Would you need to adjust your natural style in order to fulfill your foster parent role effectively?

   _____
   _____
   _____
   _____
   _____

3. How do you feel about being an advocate for a child in your care? What does being an advocate mean to you in terms of what actions you might have to take on behalf of a child in your home?

   _____
   _____
   _____
   _____
   _____

4. Do you have any other questions or concerns about your responsibilities as a foster parent?

   _____
   _____
   _____
   _____
   _____

Evaluation of Module 4

In order to assist the facilitators in planning and structuring future training sessions, we welcome your comments and suggestions. This form should only take a few minutes to complete. Thank you.

Please rate how well the session helped you to attain the following objectives.

1. I am aware of the ministry's commitment to the guardianship team approach.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

2. I have a better understanding of the roles and responsibilities of guardianship team members.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

3. I have a better understanding of the role and responsibilities of foster parents.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

4. I found the presentation and involvement of a guest foster parent in this session to be helpful.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

5. I think that I am getting a good idea of the expectations and requirements of foster parents in British Columbia.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

6. I feel at ease and involved in these sessions.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Comments?

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Module 5

Positive Caregiving and Styles of Parenting

Participant Resources

Module 5:
Positive Caregiving and Styles of Parenting

Participant Resources and Handouts

5-1 **Understanding Challenging Behaviours**

5-2 **Some of the Reasons Abuse and Neglect Occur in Foster Care**

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Evaluation of Module 5

Understanding Challenging Behaviours 5-1

Children who come into care have often been through some trauma and their past may include abuse, neglect, maltreatment, personal difficulties, separation, loss and grief. We have learned that these experiences impact on development and behaviour. Children may be delayed in their physical, intellectual, social, emotional or sexual development. Or, they may behave in ways that are inappropriate for their age and their stage of development. The behavioural impact manifests itself in a wide variety of ways. Given these life experiences, it is not surprising that a child who is in care presents challenging behaviours. These are not 'bad' behaviours – they are a logical outcome of what the child has gone through.

All behaviour has a purpose

All behaviour has a purpose. Your challenge as a foster parent is to understand that underneath each behaviour – challenging and otherwise – is a need or goal. If you can uncover this need or goal, you are better able to determine what short-term and longer-term interventions will work for that child. By 'working' we mean that the child's underlying needs will be more effectively addressed, resulting in behaviour that is more appropriate and that the child will feel better about themself.

The goals of challenging behaviour

A child usually 'misbehaves' or presents challenging behaviours when they are discouraged and feel that they cannot belong, be accepted or succeed through appropriate behaviour. The child may feel that it is better to get a negative reaction than no reaction and therefore may behave in ways that are uncooperative and disrespectful, or harmful or dangerous to themself or others. There are five major goals of challenging behaviours:

- attention
- power
- revenge
- display of inadequacy
- self-protection

Each of these goals will be described as well as indicators that you can look for to determine which of these goals might apply to a child's behaviour.

Attention

All children need and will seek attention. Some children have a greater need for attention and may seek it in less positive or even destructive ways. The sequence of events often goes like this:

- child behaves in ways that are annoying or frustrating for the caregiver
- the caregiver steps in to correct the behaviour and may express their frustration or disappointment to the child
- child's need for attention has been temporarily met and the behaviour stops
- the cycle repeats itself.

Power

All children need to feel that they have some control over their lives. Children who have experienced abuse and neglect have often been stripped of any sense of control. Children raised in chaotic home situations or who have experienced multiple separations and losses feel that they have no control. These children may need to exert control and authority or power. They may believe that the only way that they can belong is by being 'the boss' and will fight for their power. The sequence of events often goes like this:

- child attempts to assert their power and control either actively (e.g., yelling, physical aggressiveness) or passively (e.g., ignoring requests, completion of tasks on their own terms)
- caregiver gets angry and may express their anger through yelling, escalating demands, setting consequences or punishing
- the child fights back and they are both locked in a power struggle that may be damaging to both of them
- if the caregiver gives in, the child's need for control and power has been temporarily met and the behaviour stops
- the cycle repeats itself and the seriousness of the behaviour may escalate.

Revenge

Some children want to have control and power but have not been successful in power struggles with caregiver. They may decide that they need to get even or seek revenge. There are many different ways that children may behave to seek revenge. The sequence of events often goes like this:

- child says or does something hurtful or harmful to the caregiver
- the caregiver feels hurt and angry and may try to get even by blaming or shaming the child, escalating demands, setting consequences or punishing the child
- the child may respond with further attempts to get even and a growing 'war' of revenge ensues
- both the child and caregiver have angry and hurt feelings
- if the caregiver gives in, the child's need for revenge is temporarily met and the behaviour stops
- the cycle repeats itself and the seriousness of the behaviour may escalate.

Displaying inadequacy

Some children just give up. Their behaviour says. "I can't do it, just leave me alone." They believe that they are inadequate in one or more areas of life and have a sense of hopelessness about themselves and their future. They may act in ways that confirms their belief about their inadequacy such as intentionally making a mistake or failing at something. They may re-interpret simple mistakes or errors as major indications of their inadequacy. The sequence of events often goes like this:

- child says or does something that conveys that they are inadequate and unable to do something, the child gives up on themself
- the caregiver feels like giving up too
- if the caregiver does give up and expects nothing from the child, the child's goal has been met
- the child's belief about their inadequacy is reinforced and may extend to other areas of life so that the cycle repeats itself.

Self-Protection

Some children believe that they must protect themselves from harm or danger. In some situations the threat of harm or danger is real and in others it is perceived. Many children who must come into care have been threatened with or experienced harm and danger and their behaviour may make logical sense to them although not to the caregivers who are trying to create a safe, supportive place for them.

How does it help to understand the goals of challenging behaviour?

Children don't understand that their behaviour is goal directed. They may use similar behaviours to attain several different goals. The key to understanding the child's goal is look at three clues: how you feel when the child behaves in this way, what you do in response, and what the child does in response.

By understanding the motivation (purpose) of the child's behaviour you can:

- make a more informed decision about how to respond to challenging behaviour, and
- avoid reinforcing the behaviour through you own response.

Some of the Reasons Abuse or Neglect Occurs in Foster Care 5-2

Some possible reasons why children in care are at risk for abuse and neglect

Children who are unable to communicate about abuse or neglect:
- very young children
- pre-verbal or non-verbal, because of physical or developmental disabilities, deafness, psychosis or emotional disturbance
- diversity of cultural backgrounds

Children or youth who cannot tell what abuse or neglect is:
- previously abused (sexually, physically or emotionally)
- have lacked parenting
- may set up pattern to re-enact abuse or act out abuse on other children, natural, foster or those in the neighborhood
- cultural/religious beliefs

Children or youth whose behavior is challenging due to complex problems:
- physical aggression
- short attention span, restlessness and high activity levels
- have not been parented and have lacked routines, structure and limits on behaviour in their own homes
- experiencing life changes that cause stress on themselves and their foster parents, such as upcoming court hearings
- changing developmental stages
- children whose behaviour, communication and home expectations are culturally different from their foster family

Children who have experienced many changes:
- frequent placement moves and changes in caregivers
- changes in child workers

Children who experience difficulty in forming attachments:
- some children have tremendous difficulty in forming healthy attachments and may be unable to do so with their caregivers. This is very difficult for many caregivers and heightens stress and frustration.

Some of the possible stresses and situations for foster families that may contribute to the risk of abuse, neglect or breach of rights occurring:

- lack of experience in parenting troubled children or youth
- community views about fostering and reactions to foster family
- relating to and dealing with "systems" (the child care system, schools, health care professionals i.e., doctors, public health nurse, psychologists)
- changing foster family dynamics and communication patterns with each new child placed in the home
- use of corporal punishment for family's own children and limited knowledge of alternative techniques for behavior management
- past histories of abuse that have not been dealt with
- experiencing marital problems, financial difficulties, problems with other children or family members
- experiencing significant transitions such as marital separation or divorce, illness or death of family members, job changes or loss
- lack of support systems and not knowing how to access help
- unrealistic or high expectations and ideals about foster children
- hesitation in asking for help for problems arising from fostering
- lack of preparation and commitment of whole family to fostering (spouse or partner, other household members)
- ongoing lack of using respite to take regular breaks from fostering and other responsibilities
- not feeling a part of the foster care team

Safeguarding Children and Families 5-3

Some guidelines to make foster care a safer experience for children and foster families.

1. **Obtain all applicable information you can about the child prior to placement.** Pre-placement information is necessary to enable you to adequately assess your home's ability to foster this child at this time. You may want to include the following areas in your discussion with the child's worker about the child:
   - background
   - relationships and attachments
   - developmental level
   - view of things
   - individual needs (health, emotional, social, physical)
   - significant life experiences
   - separations and losses that they have experienced
   - details of any abuse or neglect experienced by the child and the effects of the abuse or neglect on the child
   - details regarding any special behaviours which result from the child's abusive experience
   - has the child made allegations of abuse or neglect toward other caregivers
   - other caregiver's experiences with the child

2. **Obtain and review copies of the *Standards for Foster Homes, Foster Family Handbook, Rights of Children/Youth in Care* booklet and the ministry's *Complaints Resolution Process*.**

3. **Observe the Rights of Children in Care**: Children in care have legislated rights under section 70 of the *Child, Family and Community Service Act* of British Columbia. Foster parents must know and observe these rights; their inclusion in the act makes them law.

4. **Follow the ministry's legislation and Standard for Foster Homes regarding acceptable discipline**. Foster parents must accept and adhere to the Standard for Foster Homes on Positive Parenting and uphold the right of children in care under the *Child, Family and Community Service Act* to be free from corporal punishment. Know what are prohibited behaviour management methods.

5. **Keep a daily log for each child in your care**. Keeping daily records allows you to review situations, provides your child's worker with additional information that can help decision-making, maintains a records of accidents, fights or disagreements and allows you to maintain a record of how you handled these situations. Recording should include both positive and negative situations that your children have encountered each day. Keep in mind that you must report any significant incident to the child's worker.

6. **Build and maintain a support system**. As a foster family you need better support systems than most people. You may have additional pressures caring for children who often have challenging and complex needs. Support can come to you from participating in meetings of your local B.C. Federation of Foster Parent Associations, through close friends or from your own extended family. If there is no support group through your local foster parent association then help establish one. It is very important that you have someone to turn to in times of crisis.

7. **Establish and follow "House Rules."** Most families, including foster families, have some guidelines which shape family life. What is suggested is that these become more explicit, in some situations:

   - House Rules should be based on the history and the special needs of the foster child.
   - They should be developed in conjunction with the child's worker.
   - House Rules may be previously existing rules of the family, or more detailed rules may be necessary.
   - Have clear basic rules about:
     - *Privacy:* All family members should know and respect family rules regarding privacy. This includes who is allowed in whose bedroom and under what circumstances. Expectations about bathroom utilization should be made clear.
     - *Dress:* A reasonable dress code which also addresses the issue of nudity should be established.

8. **Know your family**. It is important to be aware of how fostering is affecting your own children and other family members. Take notice of changes in your children's behavior or significant changes in the way your family interacts. "Checking in" with family members provides opportunities for:

   - being heard
   - expressing positive feelings about one another and giving encouragement
   - expressing concerns, feelings and complaints
   - settling conflicts as they arise

9. **Do not leave your children or other children alone without an appropriate authorized adult present**. Reasonable "common sense" guidelines should be established regarding who should be left alone with whom, for how long and in what circumstances. In certain cases where children with histories of child abuse or with serious emotional and behavioural problems more specific rules may be necessary.

10. **Maintain open communication**. During each placement, it is important to keep the child's worker and your resource worker advised regularly of both the successes and problems. If there are changing dynamics in the foster family, such as illness in one foster parent or behaviour changes in the foster child or youth, then tell your worker. If your foster child has an issue let the child's worker know as soon as possible.

11. **Obtain copies of the Foster Home Protocols**:
As foster parents, you share the ministry's responsibility to protect the safety and well-being of children in care. Carrying out this responsibility in day-to-day life is not always easy. Foster families face a lot of challenges, and sometimes these lead to differences between foster parents and ministry staff.

Most issues can be worked out by talking things over with a child worker. But others cannot. Three special situations require a formal process – called a protocol – that clearly spells out what will happen and when.

The first situation is when the ministry receives a report that a child in care in your home has been abused or neglected. In a case like this, the ***Protocol for Investigating Reports of Abuse or Neglect in Foster Homes*** is followed.

The second is when someone has a concern about the quality of care a child in your foster home is receiving. In this case, the ***Protocol for Reviewing Quality of Care Concerns*** is followed.

The third is when you and ministry staff cannot agree on an issue. In this case, the ***Protocol for Resolving Issues Between Foster Parents and Ministry Staff*** is followed.

12. **Participate in training**. Foster parents who have a Family Care Home agreement with the Director have free access to the 53-hour B.C. Foster Care Education Program for foster parents. This program, delivered through B.C.'s provincial colleges, is a requirement for all foster parents in their first two years of fostering with the ministry.

Many children proposed for placement have needs that require special care. These may include children with physical or developmental disabilities, medically fragile infants or children with serious emotional or behavioural difficulties. Receiving specific training helps foster parents. Prior to placement, foster parents should request and receive specific training to equip them to understand and care for children who have needs that require special care.

13. **Know your limits. Ask for help,** if you or your family are unable to manage the needs of the child placed in your home. Sometimes it is difficult for foster parents to ask for help in caring for a child placed with their family. Foster parents may feel inadequate, or may be concerned that the child worker will view them as failures when they seek assistance. Consequently, they may wait until very serious problems arise before asking for help. Working closely as team can be a challenge. However, most successful foster care placements involve a close partnership among foster parents, the child's worker, and their resource worker. *This includes the practice of foster parents asking for and receiving appropriate help when problems first arise.* Keep a list of contact people.

Emergencies:

When an emergency happens outside office hours (normal hours for ministry offices are 8:30 a.m. to 4:30 p.m., Monday to Friday), phone the ministry's After Hours Line:

- In Vancouver, the North Shore and Richmond, call **660-4927**.
- In the Lower Mainland from Burnaby and Delta in the west to Maple Ridge and Langley in the east (all within the Vancouver free-calling area), call **660-8180**.
- For the rest of the province, call toll-free at **1-800-663-9122**.
- **Poison Control Centre – 1-800-567-8911** from anywhere in B.C.
- **Helpline for Children** (to report child abuse or neglect, **Dial 0** and ask for the Ministry for Children and Families Helpline for Children from anywhere in B.C.)

Other Useful Resources:

B.C. Federation of Foster Parent Associations (BCFFPA)
(604) 660-7696 or toll free at **1-800-663-9999**

Foster Families Support Line
1-888-495-4440 4:00 p.m. – 12:45 a.m., Monday to Friday
8:00 a.m. - 12:45 a.m., statutory holidays and weekends

Child, Youth and Family Advocate
1-800-476-3933 from anywhere in B.C. or **775-3203** in the Vancouver calling area

Children's Commission
1-800-859-1441 from anywhere in B.C. or **356-8963** in the Victoria calling area

Ombudsman
1-800-567-3247 from anywhere in B.C. or **387-5855** in the Victoria calling area

Public Trustee
(604) 660-4444

Possible Reasons for Abuse or Neglect Allegations Occurring in Foster Homes 5-4

- A child in care may misinterpret a foster family member's action or expression. Children in care who have experienced abuse and neglect may interpret certain events and actions as threats to their safety and well-being.
- A child in care may misinterpret a foster family's practices, events or traditions. Children in care have experienced different parenting, family and cultural practices than those in the foster family and may misunderstand or misinterpret events and actions.
- A child in care or someone in the child's family or circle of friends may be angry with or have a grudge against the foster family and use an allegation of abuse as a threat or weapon.
- A child in care may want or need to leave a placement and makes an allegation to force a move.
- A child in care may feel disloyal to their family and attempt to break down the placement or prove that the foster parents are "bad" in the hopes of showing loyalty to their family.
- A child in care may feel out of control and make an allegation in order to have more power and control over their situation.
- A child's family may feel angry, hurt, guilty or depressed about their children coming into care and may make allegations against the foster parent in an effort to regain some control over their situation.
- A child's family may feel jealous of the foster parent and the foster parent's relationship with their child and may make allegations against the foster parent in an effort to control the relationship.
- Community members may not understand the nature of the child in care's development, behaviour and needs and may misinterpret events or actions of the foster parent.
- Actual physical, emotional or sexual abuse has occurred in the foster family. The abuser can be one of the foster parents, other foster children, natural children or a visitor to the foster home.

Standard on Complaint Resolution 5-5

STANDARD A.3. Complaint Resolution

Children are encouraged to express their concerns and any complaint is addressed seriously and without delay.

Commentary

It is important that children and youth in care become comfortable in asserting themselves in constructive ways, including when expressing dissatisfaction. Providing an environment of care in which children and youth are encouraged to express dissatisfaction in a constructive manner will reduce the likelihood of circumstances deteriorating to the point where a formal complaint is registered.

Results for Children

A.3.1 Children confirm that the caregiver encourages them to bring their concerns into the open and has supported, or believes the caregiver would support them to formulate and present a complaint to the appropriate authority.

A.3.2 Children confirm that they are aware of the internal complaints process of the Ministry for Children and Families.

A.3.3 Children confirm that they are informed about and assisted to contact the Child, Youth and Family Advocate.

A.3.4 Children who have made complaints confirm that the complaints were dealt with, even if not resulting in agreement.

Caregiver Practices

A.3.5 The caregiver assists children in understanding that they are entitled to discuss all matters, including any problems or complaints, affecting them with their social worker, their caregiver or other appropriate authorities. Other appropriate authorities include, but are not limited to:

a) the Child, Youth and Family Advocate;
b) the Ombudsman;
c) the Information and Privacy Commissioner; and
d) the Children's Commission.

A.3.6 The caregiver informs the child about and assists them to contact the Child, Youth and Family Advocate.

A.3.7 The caregiver assists children in understanding that there will be no reprisals for lodging a complaint.

A.3.8 The caregiver keeps a record of the incidence and outcomes of complaints.

Source: *Standards for Foster Homes* © 1998, Ministry for Children and Families

Standard on Positive Parenting 5-6

STANDARD D.1. Positive Parenting

Children receive positive parenting.

Commentary

While children have the responsibility to adhere to a reasonable standard of behaviour, they have the right to know the standard of behaviour expected of them by their caregiver as well as the consequences for not meeting the caregiver's expectations. It is expected that caregivers will apply reasonable consequences sensitively and fairly, according to the child's level of development. In order to develop positive behaviour and social skills, children need to grow confident in their own ability to distinguish right from wrong. One way children learn positive behaviour and social skills is by observing and imitating adults who are worthy behaviour models.

Results for Children

D.1.1 Children confirm that they receive the same quality of care as other children in the placement, including the caregiver's own children.

D.1.2. Children confirm that the caregiver is interested in and cares about them as individuals.

D.1.3. Children confirm that the caregiver assists them with issues which arise from daily living and developing appropriate behaviour.

D.1.4. Children confirm that the caregiver does not use prohibited behaviour management methods.

D.1.5. Children confirm that they have been informed of the standard of behaviour expected by the caregiver and the consequences for not meeting the caregiver's expectations.

Caregiver Practices

D.1.6. The caregiver ensures to the fullest extent possible that the child receives the same quality of care as other children in the placement, including the caregiver's own children.

D.1.7. The caregiver ensures that caregiver practices are consistent with the child's individual needs.

D.1.8. The caregiver provides care and supervision appropriate to the child's age, level of development and ability to accept independence and responsibility.

D.1.9. The caregiver uses positive parenting methods. Positive parenting methods include those actions that:

a) are based on praise, encouragement, and structuring the setting for success;
b) are motivated to assist the child to learn responsibility and self-control;
c) teach or model appropriate ways of behaviour;
d) are reasonable and directly related to the child's behaviour; and
e) respond to the child's behaviour as soon as possible.

D.1.10 The caregiver, if authorized, assists the child's family to understand and use positive parenting methods.

D.1.11. The caregiver does not use the following prohibited behaviour management methods which are expressly forbidden:

a) deprivation of a child's or youth's basic rights or needs (for example: food, clothing, shelter, bedding);
b) physical discipline (for example: spanking, shaking, slapping, hitting);
c) degrading actions (for example: humiliation, ridicule);
d) restraint, other than for the immediate physical safety of the child or youth, other children or youth, the caregiver or others;
e) seclusion (not including time-out) or confinement;
f) assignment of unreasonable exercise or work that may be excessive or harmful to the child or youth;
g) threats of removal from the care setting in order to manipulate or coerce the behaviour of the child or youth;
h) arbitrary or unauthorized denial of visits, telephone contact or correspondence with family members or guardians;
i) application of consequences in situations where it is not certain that the individual's behaviour has warranted them;
j) being disciplined by another child who has not been designated as temporary caregiver; and
k) coercive behaviour by the caregiver regarding their religious or personal beliefs.

D.1.12 The caregiver informs the child of the standard of behaviour expected by the caregiver and the consequences for not meeting the caregiver's expectations.

D.1.13. If having difficulty managing the child's behaviour, the caregiver consults with the child's social worker as soon as possible, and with the child's parents if authorized.

Source: *Standards for Foster Homes* © 1998, Ministry for Children and Families

Positive Parenting 5-7

'Positive Parents' seek to:

1. **Understand and respect the child, their experiences, feelings, needs and situation**
2. **Understand themselves and how they react and respond to certain behaviours or situations**
3. **Build a respectful and positive relationship with the child**
4. **Understand the reasons for a child's behaviour**
5. **Create the conditions for a child to learn**
6. **Set appropriate limits and consequences**
7. **Give children choices within those limits**
8. **Provide daily care for the child with a view to the child's long-term best interests**

The goal of Positive Parenting is to:

1. **Create a healthy environment for the child and the caregiver**
2. **Help children develop and learn self-discipline and responsibility**
3. **Support attachment, continuity and stability**

Understanding a child

Before we can set limits and give choices, we need to understand the child and what can reasonably be expected. Some things to consider are:

1. Temperament or the child's unique style of behaving - This refers to the unique qualities a child is born with, e.g., some are active, others calm; some like to be around people, others prefer to be alone

2. Developmental ages and stages - Each child develops at their own rate and their life experiences may have a dramatic impact upon their development. Therefore it is important to understand where a child is at developmentally so that we understand what we can expect the child to do and what we might do to attend to the child's developmental needs. For young children, it is important to create a baby- or child-friendly environment so that the risk of harm is reduced.

3. Life experiences - The child's life experiences may have a significant impact upon their view of themselves and their view of others. Developing an understanding of the child's experience and how they have made sense of it and responded to it assists us in determining how best to parent the child, what can be expected and what can be worked on.

To develop your understanding of the child along these dimensions you must gather information by talking to people who know the child (including the natural family members if appropriate), observe the child, listen to the child, talk with the child and try to put yourself in the child's shoes. You are engaged in a process of continuous learning.

Under tanding yourself
When you develop self-awareness and understand how you react and respond to certain behaviours or situations you are better able to take control of your own feelings and thus your response.

Building relationships with a child

All of us need and want to 'belong.' Many children who must come into care have had experiences where they haven't belonged, where the people who they had a right to expect would care for them, are unable or unwilling to do so. Trust and relationships have been violated. This presents a challenge to foster parents as the children in their care may understandably be reluctant to trust or allow for a relationship with them. There are different levels of relationships and in most cases it will take time to build up a significant and healthy relationship with a child placed in your home. However, positive relationships are key to promoting a child's healthy development, competence and self-esteem.

Positive relationships embrace the following:
1. Mutual respect and acceptance
2. Trust
3. Consideration
4. Support and encouragement
5. Desire to communicate
6. Willingness to resolve conflict constructively

Relationship-building strategies include:
1. Spending time together
2 Showing respect
3 Giving help and encouragement
4. Using play, humour, fun and 'special times'
5. Creating a home environment that is safe, supportive, accepting and nurturing

Create the conditions for a child to learn

We all learn best in a climate of support, encouragement, stimulation and assistance. Our learning is supported when we are clear about expectations and consequences, these expectations and consequences are realistic for us and we have access to or are provided with the necessary information, tools and guidance to proceed with learning. The role of the caregiver is to create these conditions for learning so that the child can tap into and access their innate capacity and potential to develop knowledge, skills and abilities.

Setting appropriate limits and consequences for a child

Some caregivers think that they must control their children and establish strict rules. They fear that without this the children will control them. But children want and need to have some control also. Having some control, in a positive way, helps children to develop responsibility and competence. A more appropriate and effective alternative to 'having control over' children is to set limits.

Children need limits – they need a flexible sense of order and will grow anxious without it. Appropriate limits help children to:

1. Feel safe and secure
2. Know how far they can go
3. Learn how to be self-limiting and to take responsibility for their own behaviour
4. Try out new ways of behaving within a safe frame of reference

As the child grows, develops and gains skill and competence, the limits or boundaries will expand. The child's readiness determines how the limits or boundaries expand. Some limits can be negotiated. Others cannot be negotiated – typically for value, safety or health reasons.

Effective limits:

1. Are consistent with the developmental stage and capacity of the child
2. Are communicated so that the child understands what is expected and what the consequences of not operating within the limits will be
3. Have consequences that are focused on the child's behaviour and not on the worth of the child (Note: natural and logical consequences are discussed in detail in a later section)
4. Assist the child to learn how to be self-responsible and self-managing

Give a child choices within those limits

Within the appropriate limits you may give a child choices. Having a choice helps the child to have some positive control and grow to be more responsible. Examples include:

1. When two children are playing loudly in the living room where other family members are trying to have a conversation, you may say "This room is not a loud play room and we are trying to have a conversation. You may settle down and stay with us in this room or you may take your roughhousing outside, you decide."

2. When a 13-year-old wants to go to evening events three nights in a row, you may say "It is important to us that you be involved in some family activities as well as activities with your friends. You may choose which two of the events with your friends you would like to go to and stay home with us on the other night."

Provide daily care for the child with a view to the child's long-term best interests

As a foster parent you will be responsible for the daily care of a child or children. This daily care involves the provision of basic goods such as shelter, food and clothing as well as the essentials of acceptance, nurturing, support, education and guidance. Through daily care and activities there are opportunities to promote the child's long-term best interests, including healthy development, the promotion of attachment, continuity and stability, and development of a sense of self-worth and self-responsibility.

Regardless of the age and developmental level of the child, the daily care that you provide should seek to:

1. Accept the child for who they are and where they are developmentally
2. Demonstrate respect for the child
3. Model your values
4. Respond to the problem rather then react negatively to the child
5. Provide guidance or assistance for learning
6. Promote your and the child's learning, including from mistakes
7. Emphasize and encourage a child's achievements
8. Emphasize co-operation
9. Be flexible and adaptable; learn new approaches and be willing to seek the child or youth's views and adapt your response based upon their input

Positive parenting is particularly important for children in care.
It is crucial to realize that while our tendency as adults is to treat a foster child "like any other kid," there are some important differences. Their previous life experiences affect their understanding of everything that happens – even what we may consider innocuous talk and behaviour. Our own children grow up with us and thus, instinctively, know what we mean, what the rules are and how we will respond to most situations. They tend to know when we are "blowing off steam" and when we "mean business." Foster children can and should be treated differently from one's own children. It is helpful if foster parents have a range of flexible responses that give them a chance to understand how children respond and how they perceive the world.

Preparing Children and Youth for Positive Relationships and Responsibility 5-8

For children in care who may have experienced rejection by their parents, a history of multiple moves or placements, inconsistent caregiving, separation from siblings, unstable or unpredictable conditions for having basic needs met, and feelings of 'being different' from peers because they are in foster care, it is often difficult to develop positive relationships and to act responsibly. An important part of caring for all children is helping them to develop the ability to form positive relationships and to act responsibly. These are essential characteristics for an adult to experience success in intimate relationships, relationships with friends and family and on the job.

Suggestions for Preparing Children and Youth for Positive Personal and Family Relationships

- Model the effective expression of feelings and needs
- Express appreciation to those you care about
- Teach children how to empathize
- Teach children to understand the point of view of others
- Encourage children to join groups where cooperation and teamwork can be practised
- Provide recognition for children's friendships
- Model relationship qualities you would like children to develop (trust, openness, commitment)
- Demonstrate appropriate affection
- Give constructive feedback about the manner in which children interact with others
- Involve children in family life and decisions
- Respond to conflict constructively
- Involve yourself in activities that the child likes
- Provide praise for child's contributions around the house
- Support the child's efforts to help care for younger siblings

Suggestions for Promoting Self-Esteem

- Avoid criticism
- Praise accomplishments
- Provide opportunities to experience success
- Encourage interests and completion of tasks
- Spend time with the child
- Compliment physical appearance or hygiene
- Recognize a child's individuality and nurture it
- Show an interest in the events of the child's day
- Encourage perseverance
- Provide positive reinforcement ("you can do it," great going, excellent)
- Celebrate birthdays, holidays and children's special occasions

Suggestions for Preparing Children and Youth for Responsibility

- Encourage initiative and eagerness to take on responsibility
- Provide praise for the completion of manageable assigned tasks
- Provide choices and allow children to make decisions for themselves
- Allow children to experience consequences of behavior
- Let children know that their contributions to the family home are important
- Encourage and support children in learning and practising all skills related to adult living
- Discuss relevant issues such as sexuality, drugs and alcohol
- Assist in the resolution of value and ethical dilemmas
- Involve children in household chores such as cleaning, cooking, shopping
- Help children budget their own money
- Balance limits with the freedom to be responsible and competent
- Assist youth in identifying and pursuing educational/vocational goals

Examples of Assessing and Responding to a Child's Challenging Behaviour

Instructions: In your sub-groups, fill in the missing boxes.

Child's Behaviour	Caregiver Reaction	Purpose/Goal/ Needs of Behaviour	Helpful Response By Caregiver
Child punches you while you are on the telephone.			
While shopping, child sits down on the floor and refuses to budge.			Acknowledge that child doesn't want to be there; seek agreement as to how child's needs at the moment can be met.
Child breaks window in room after being told "no" to some request.			
Child comes home and says: "I didn't make the team; I'm f ---ing useless!"	I feel helpless, unable to assist.		
Child says "leave me alone" and runs to room and slams the door.		Child is trying to protect herself/ themself from difficult situation.	

The Differences Between a Discipline Approach and Punishment

Discipline Approach	Punishment
1. Emphasis on preventing the problem before it occurs.	1. Emphasis on dealing with problem after it occurs.
2. Consequences are discussed together by adults and youth (whenever possible in advance of the problem).	2. Consequences are set by adults (usually following the problem).
3. Emphasis is on teaching the reality of interpersonal relations and the need for co-operation.	3. Emphasis is on the reality of adult authority.
4. Requires internal control.	4. Relies on external control.
5. Assumes that inflicting physical and psychological pain are NOT acceptable.	5. Assumes that inflicting physical and psychological pain are acceptable.
6. Re-involvement and resuming of normal relationships is priority.	6. Exclusion and rejection are a priority.

Module 5 Take-Home Sheet
Discipline and Parenting Practices

In Module 5, the issues of understanding behaviour, discipline alternatives to punishment, and factors affecting potential abusive behaviours and how to guard against them have been considered. The following questions will give you an opportunity to review some aspects of these topics in relation to your family's readiness for fostering.

1. What are the ways in which you discipline your children? Are these discipline alternatives or are they punishment?

2. How do you feel about the ministry's list of prohibited behaviour management methods and the child's legislative right to be free from corporal punishment? What changes might these provisions mean for you?

3. What do you think of the process of identifying the goal or need behind a child's behaviour, being aware of your personal reaction, and trying to adjust your behaviour to influence the child? Do you see any problems with adopting this approach?

4. Are you willing to call on others in times of stress? Would you make use of the resource people (e.g., ministry team members, B.C. Federation of Foster Parent Associations, friends and family members) around you?

5. Do you have any anxieties or concerns about the ministry's expectations regarding caregiving or safeguarding the children in care and your family?

Evaluation of Module 5

In order to assist the facilitators in planning and structuring future training sessions, we welcome your comments and suggestions. This form should only take a few minutes to complete. Thank you.

Please rate how well the session helped you to attain the following objectives.

1. The presentation and discussion on the purposes of children's behaviour was interesting and helpful.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

2. The session helped me to be aware of how to safeguard the foster child from feeling neglected or abused while in the foster home.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

3. The session helped to clarify the differences between discipline and punishment.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

4. I have a good understanding of what it means to have a "positive parenting" approach.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

5. The session presented helpful strategies for responding positively to children.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

6. I am finding these sessions are helping me to make a realistic decision about my readiness to foster.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Comments?

_____

_____

_____

_____

Module 6

Preparing for Placement

Participant Resources

Module 6:
Preparing for Placement

Participant Resources and Handouts

6-1 Foster Parents' Pre-Placement Checklist

6-2 Supporting the Child Upon Placement

6-3 Placement Considerations — What Can Caregivers do to Help?

6-4 Practicalities in Preparing for Placement

6-5 Standard B.2 Reportable Incidents

6-6 Reducing the Risk of Sudden Infant Death Syndrome

6-7 Standard Precautions

6-8 What are the Health Files?

6-9 Standard E.2 Safety and Emergency Practice

6-10 Standard F.2 Individual Service Records

6-11 Rights of Foster Families

Handouts
6:1a Placement of Sarah, Jason and Darren
6:2b Placement of Mosha
6:3c Placement of Nathan
Evaluation of Module 6
Overall Evaluation of Orientation

Foster Parents' Pre-placement Checklist 6-1

Foster parents often wish they had asked more questions before accepting a child into their home. This checklist is a guide to help you in your discussion with the ministry.

- ❒ Why is the child being placed?
- ❒ What are previous placement experiences of the child?
- ❒ What is the child's legal status?
- ❒ What is the family situation? Parents' names?
- ❒ What is the expected length of placement?
- ❒ Will there be pre-placement visits by the child?
- ❒ Does the child understand why he or she has moved or been separated from the parents?
- ❒ Where are the parents?
- ❒ Will the parents or extended family visit? Where? How often? Are there people who are not permitted to visit or have contact with the child?
- ❒ Are there brothers or sisters? Where are they? Birthdates?
- ❒ When will the child's worker visit or call?
- ❒ When will I receive the referral form from the child's worker, giving important personal information about the child?
- ❒ When will I receive the child's Health Care Passport?
- ❒ When was the child's last physical examination?
- ❒ Is the child in good health? What about allergies, immunizations, medications, dental care, last dental checkup?
- ❒ Are there significant religious, cultural or ethnic considerations for this child?
- ❒ What grade is the child in at school? What school?
- ❒ Are there school problems?
- ❒ Has the child any special behavioural problems or unusual habits?
- ❒ Could any of the child's behaviours pose a risk to other children?
- ❒ Will the child have adequate clothing?
- ❒ What transportation needs to be provided for this child?
- ❒ What will make the child feel most at home (food likes and dislikes, favourite toys, and so on)?
- ❒ Who should I call after hours, and what is the number?
- ❒ When will I meet with the child's worker to review the caregiver's responsibilities section of the child's Comprehensive Plan of Care?

Supporting the Child Upon Placement 6-2

(adapted from: B.C. Federation of Foster Parent Associations)

Things to Expect

The first few months of placement are often like a roller coaster ride. Everything starts out smoothly, and foster parents may think, "Why was I worried – this is great!" (child workers often call this the "honeymoon period"). Then – WHUMP – DOWN goes the fostering situation. After a series of ups and downs, things level out and more or less settle down.

In the first three to six months of placement, children often show physical symptoms, such as minor illnesses, colds, chest infections, too much or too little appetite, intestinal upsets, etc. These are normal responses of children to situations of intense stress. Coupled with these physical symptoms are a number of behaviours. When children lose their sense of stability and familiarity with their surroundings, they may:

1. Show a loss of self-control and a loss of learned skills, e.g., "He flies off the handle at the least little thing," or a toilet-trained three-year-old starts wetting the bed.

2. Show a loss of self-initiative, e.g., "clings all the time," "can't seem to find anything to do," "I have to tell him everything, every time."

3. Show a diminished ability to stop things once started, e.g., "My goodness, the kid just kept going on and on."

4. Show a diminished sense of time.

5. Show a decreased ability to learn.

These behaviour changes are usually temporary, but with severely damaged children, especially those who have moved too often, too many opportunities have been lost and helping them is a long, intense process.

What Can Foster Parents Do to Help?

1. Encourage the child to bring and/or keep familiar clothes, toys and belongings. New things are great, but that raggedy, moth-eaten, scrunched-up teddy bear might be a best friend to the child.

2. Remember that, apart from things looking familiar, the child may be keenly aware of smelling familiar things, and feeling familiar objects. (You may recall what it is like when you go into a motel or stay with someone else – how the rooms smell or the sheets feel can either put you off or relax you.)

3. Try to find out what things the child likes – particular foods, clothing, games, activities, music, TV programs, etc. Even if the fostering family needs to change a bit, making room for some of these things will help the child relax and feel more at home.

4. Talk with the foster child about routines – when they get up, go to bed, eat, play, wash, etc. Foster parents should explain what they expect, and why. Acknowledge that your family's routine may be a change for the child.

5. Try to involve the child in making decisions; at this point, being in control of very small things can be comforting and reassuring to them. Realize, however, the children may have real difficulty in taking responsibility. The most natural reaction may be to defer to everything they believe the foster parents want.

6. Talk with the child about names – what would they like to call their foster parents, what choices can the foster parents give them?

7. Be open and honest with the child about what is happening! Foster parents may share what they know with the child. Remember, in the absence of solid information, children fantasize.

   Foster parents are advised never to belittle or criticize the child's parents. To reject the child's parent(s), in the child's view, is to reject the child. Very few children have an identity that is not closely linked to their parents. Help the child identify what information they would like to have, and how to obtain it.

8. Be patient.

9. Ensure the child has some privacy, both physical and emotional. Let the child have some control over what is shared with foster parents, and when it is shared.

10. Respect the child's lack of understanding of what is expected. It can take time for the child to adjust to the foster family. So, foster parents may need to devote extra time and effort to establishing good communication.

Placement Considerations - What can Caregivers do to Help? 6-3

What can caregivers do to help the child upon placement?

- Accept the grieving process as natural and necessary – realize the child's behaviour is not usually "aimed" at caregivers.
- Give the child permission to feel sad, angry, unhappy. Help the child find acceptable outlets to anger.
- Provide lots of physical closeness, warmth and affection when the child allows new parents to do so, but do not insist if the child does not seem to be ready.
- Keep new experiences and changes to a minimum in the first few weeks.
- Give reassuring *factual* messages about the child's natural family.
- Allow visiting with the natural family if at all possible.

Ideally, much of the separation trauma can be lessened if:

- Pre-placement visiting takes place with the child present, when the previous caregivers (parents) meet the new caregivers.
- In the case of a very young child, the child is fed, bathed, placed in bed, etc. by the new parent in the presence of the previous parent.
- Many of the child's familiar toys, clothes, foods, routines, etc. continue to be used.

It cannot be over-emphasized that even though visiting with previous parents can produce short-term upsets, the gains are worth the negatives. At the very least:

- The child is not as likely to fantasize (idealize) the natural parents.
- The foster parents will have a more realistic picture of the natural parents.
- It can help calm some of the child's serious fears, for example, that the natural parents have died.

Caregivers should take care not to:

- Threaten the child – especially with removal from caregiver's home or that caregiver will "have to call the child protection worker."
- Belittle the child or the natural family.
- Give false reassurance.
- Withdraw from the child.
- Start a "keep busy" program to help the children "put it behind them," or to "keep their minds off things."

Points to consider:

- Most children will have difficulty in adjusting to their foster family until they can resolve their feelings about their natural family. Thus, children are entitled to the truth, and they need open recognition of their dilemmas.
- Children often feel it is their fault that the separation took place, and thus feel they are deserving of punishment. More particularly, children tend to believe they were rejected or abandoned by their parents due to a problem they were having at that particular stage of

development. For example, a two-year-old may believe his separation took place because he wasn't toilet-trained as quickly as his parents wished. This tends to make the problem, as he perceives it, more difficult to cope with. The results often are:

  - an inability to trust adults.
  - clinging, and fearfulness the foster parent may disappear or conversely, an overly casual attitude.

- Children may soon find themselves with conflicting loyalties – a feeling they shouldn't care for foster parents because that makes them disloyal to their own family.
- The children become acutely aware of their helplessness and total dependence on the "new adults" – often this results in anger. They may feel "things happen to me for reasons I do not understand, and when I do not expect them."
- Children will also be struggling with their sense of having been rejected, whether real or perceived.

Key questions children cope with:

- "Who will take care of me tomorrow?" (sense of urgency)
- "What is wrong with me, that my parents aren't raising me?" (sense of self-worth)
- "Who am I, and who (what) will I be like?" (sense of identity)

Remember, children have no concept of a world outside of their own. They don't understand that people live differently than they do. A caregiver's failure to respond in a familiar way, therefore, will be very alarming to the child – even when the previous care was poor. Unfortunately, caregivers and children may work at cross-purposes. The caregivers may expect children to adapt to their way of doing things while the children invest considerable time and effort in trying to get caregivers to behave as their parents did. To help the children at this point requires: an ability to accept them as they are; providing them with factual information; as well as flexibility and adaptability on the adults' part. Caregivers need to show patience in helping the child to make gradual changes.

Source: Ministry for Children and Families, Training for Child Protection Workers

Practicalities in Preparing for Placement 6-4

Helpful information about the child:

- **Information about the child**, e.g., reason for being in care, legal status, prior placement experiences, cultural and ethnic background, child's past history, developmental status, special behavioural or emotional needs, other individual needs of the child
- **Information about the child's family**, e.g., level and nature of involvement
- **Information about the child's support systems and community connections as well as other people involved in the child's life or knowledgeable about the child**, e.g., extended family members, day care or school, health care providers
- **Information about the Ministry for Children and Families' expectations and commitments**, e.g., Comprehensive Plan of Care, the supports that the ministry will make available to the child and foster family

What you can do to prepare:

- **Consider the child's experience and what they may be needing** – identify what the child may be able to bring with them that will help promote continuity and stability (pictures, favourite possessions, etc.)
- **Prepare your family**, e.g., share key information with family members; consider the likely 'fit' between the child's developmental status, experiences and needs and the lifestyle, patterns and routines within the foster family; discuss this amongst the family members and identify things that may need to be altered within the foster family in order to support the child's adjustment
- **With the ministry's permission contact prior caregivers if appropriate about their experience caring for the child**
- **Prepare the home and the child's space**, e.g., ensure that the child will have a safe, personal space within the home; ensure that the home is safe given the developmental age of the child
- **Help to prepare the child if possible**, e.g., arrange pre-placement visit, and meet the child at another location

Supporting the child's adjustment:

- **Orient the child**, e.g., to the family members, home and neighbourhood and to the family rules and expectations
- **Seek to understand the child and respond in ways that support the child**, e.g., likes/dislikes, preferences, fears, the ways in which they make sense of their experiences
- **Maintain connections wherever possible and appropriate**, e.g., day care or school, recreational activities, friendships, extended family contact
- **Respect the child's pace**, i.e., set expectations about the child's adjustment, behaviour or the development of relationships within the family that are realistic for the child
- **Help the child develop an explanation of his or her recent move for teachers and schoolmates**

Reportable Incidents 6-5

STANDARD B.2. Reportable Incidents

All information of significance to the safety and well-being of children is promptly reported to a social worker.

Commentary

If the social worker is unavailable, the report is made to another social worker or the supervisor in the same district office. After regular office hours, the report is made to an After Hours social worker. After Hours social workers are available 24-hours per day, seven days per week.

Results for Children

B.2.1. Children confirm that they have been informed about reportable incidents and about what will happen if such an incident occurs.

Caregiver Practices

B.2.2. The caregiver notifies the child's social worker immediately after the occurrence of any of the following reportable incidents in order that the child's social worker can plan for the ongoing safety and well-being of the child:

a) the death of a child or youth;
b) accident or illness of a child or youth requiring medical treatment or hospitalization;
c) allegations of abuse, neglect or mistreatment of a child or youth;
d) any displays of self-injurious or high-risk behaviour by a child or youth;
e) gestures, threats or attempts of suicide by a child or youth;
f) situations when a child or youth is missing, lost or runaway, including any subsequent information obtained about the child or youth during the absence (see Appendix 1 for more information);
g) situations when a child or youth has observed, been involved in, or exposed to a high-risk situation or disaster, such as fire or multiple abuse situation in a school, that may cause emotional trauma or post-traumatic stress;
h) any intervention by the police or law enforcement authorities with a child or youth;
i) situations involving the use of physical restraint or any other prohibited behaviour management practices;
j) the unauthorized removal or attempted removal of a child or youth from the home, facility, school or day program;
k) marked behavioural changes exhibited by a child or youth;
l) suspension of a child or youth from their school or day program;
m) plans, not previously authorized, for the child or youth to be cared for by another person overnight; and
n) any other circumstance affecting the safety or well-being of a child or youth.

B.2.3. The caregiver notifies at least the resource social worker of the following incidents in order that the resource social worker can support the caregiver in planning for the short- and long-term viability of the placement for the child or youth.

a) limitation in the ability of the caregiver to meet the safety and well-being needs of a child or youth placed, or about to be placed with the caregiver;
b) limitation in the ability of the caregiver to meet other written caregiver service expectations;
c) criminal charge or conviction of a caregiver or other member of the household;
d) court supervised parole or probation of a caregiver or other member of the household;
e) the onset or recurrence of a physical, emotional or mental condition or substance abuse problem of a caregiver or other member of the household, that could reasonably be expected to impair the caregiver's ability to care for the child;
f) serious illness or injury of a caregiver or other member of the household;
g) changes in the household composition (for example, people moving in or out of the household);
h) significant change in the caregiver's financial circumstances that have potential to affect the care of the child or youth; and
i) significant increase in the use of alternative care arrangements of the child or youth.

Source: *Standards for Foster Homes* © 1998, Ministry for Children and Families

Reducing the Risk of Sudden Infant Death Syndrome

6-6

Sudden Infant Death Syndrome (SIDS) refers to sudden and unexpected death of an apparently healthy infant usually less than one year of age, which remains unexplained even after a full investigation. On average, three infants a week are reported to die of SIDS in Canada. Although in Canada there has been a decrease in the number of infant deaths reported as SIDS, it still remains a significant public health concern. Aboriginal infants have a risk of SIDS that is higher than the risk to non-Aboriginal infants.

Although the specific cause of SIDS remains unknown, we do have some knowledge of certain risk factors. The Canadian Foundation for the Study of Infant Deaths, the Canadian Institute of Child Health, the Canadian Paediatric Society and Health Canada held a workshop in 1993 on reducing the risk of SIDS. Experts presented and discussed evidence that babies who usually sleep on the their tummy (prone position) have an increased risk of SIDS compared to babies who sleep on their back or side. Over the past several years, evidence has emerged that babies who sleep on their back have a lower risk for SIDS. Many studies report that when there was a decrease in the use of the prone sleeping position, there was also a decrease in SIDS deaths.

For sleep, we recommend that normal, healthy infants be placed on their back.

It is important to assure parents and caregivers that normal, healthy babies do not choke or have any other problems resulting from sleeping on their back, even when newly born and still in the hospital. However, there are certain health conditions that do require the tummy-down sleeping position. Parent should discuss their baby's particular needs with their doctor.

When infants are awake, some "tummy time" is necessary for developmental reasons. This will also avoid temporary flat spots that may develop on the back of their head.

Older infants may be able to turn on their own from their back to their tummy. It is not necessary to force the back sleeping position on a baby who has enough mobility to find a comfortable position.

Bedsharing is a common practice for many families. There is no evidence that an infant sharing the bed with a parent or sibling has a reduced risk of SIDS.

The risk of SIDS is increased if the person who shares the bed is a smoker, or has been consuming alcohol or taking other drugs that may decrease their responsiveness.

Maternal smoking during pregnancy or exposure to Environmental Tobacco Smoke (ETS, also known as second-hand smoke or passive smoking), or both, are significant risk factors. An infant who has been exposed either before or after birth is placed at an increased risk for SIDS compared to those infants who have not been exposed.

Some studies have suggested that using certain drugs and substances during pregnancy such as marijuana, crack, cocaine and heroin, as well as binge drinking, greatly increase the risk of SIDS. Use of these substances should also be avoided while breastfeeding.

We recommend that all infants be cared for in a smoke- and drug-free environment.

Research provides evidence that babies who become too hot have an increased risk of SIDS. However, care must be taken in applying these results to Canada, as our climate and child care practices differ. It is important for parents to know that while infants need warmth and protection from the Canadian elements, they also should not become too hot. Parents can be reassured that if a room temperature is comfortable for them, it is most likely fine for their infant, too.

We recommend that infants be dressed and covered in a manner to avoid overheating, even during an illness.

Breastfeeding has significant nutritional, immunological and psychological benefits for the health of infants and may help protect against SIDS.

We recommend that all women be encouraged and helped to breastfeed their babies.

Parents and caregivers should avoid certain products in an infant's sleeping environment. SIDS can be difficult to distinguish from suffocation, and the following recommendations will also reduce the risk of smothering. Do not use soft mattresses or soft bedding such as pillows, comforters, bumper pads and lambskin or similar products. Although there are devices sold to maintain infant sleeping positions, there is no evidence that such products are beneficial in reducing the risk of SIDS. Objects that prevent circulation of fresh air around a sleeping infant's face such as stuffed toys, manufacturer's plastic wrapping and other plastic wrap products should also be avoided.

Commercial home apnea monitors for infants are available. However, there is no conclusive evidence supporting the effectiveness of such devices to reduce the risk of SIDS.

We recommend that firm flat bedding be used for normal healthy infants, with sheets and light blankets as needed, but without products to maintain the sleeping position.

Since the cause or causes of SIDS remain unknown, parents who have lost a child due to SIDS should not conclude that their child care practices caused their baby's death. It is important to emphasize that research can only tell us how to reduce the risk of SIDS.

The Canadian Foundation for the Study of Infant Deaths, the Canadian Institute of Child Health, the Canadian Paediatric Society and Health Canada have integrated this information into existing programs and will continue to do so. There are several strategies to disseminate this information to the public and to health professionals. These organizations have worked as partners with Aboriginal representatives to address this significant health risk to Aboriginal infants.

Source: Joint Statement - Reducing the Risk of Sudden Infant Death Syndrome in Canada, by the Canadian Foundation for the Study of Infant Deaths, the Canadian Institute of Child Health, the Canadian Paediatric Society and Health Canada

from the Health files

Ministry of Health and
Ministry Responsible for Seniors

Number 29
Summer 2000

Standard Precautions

Hear this on tape:
Vancouver: 660-2628
Other: 1-877-660-2628
ID# 1405

What are "Standard Precautions"?

"Standard precautions" are steps we should take to protect ourselves when we come into contact with the blood or body fluids of other people. Standard precautions are intended to stop the spread of germs to others.

Most of the time, you can't tell if a person is infected with AIDS, hepatitis B, hepatitis C, or any number of other diseases. The best thing to do is treat the blood and body fluids of **EVERY PERSON** as **POTENTIALLY** infectious. These potentially infectious body fluids include blood, semen, and vaginal secretions.

The basics of standard precautions

Blood and body fluids – **ALWAYS** treat as potentially infectious. Clean up spills promptly using absorbant material first, then clean more thoroughly with a disinfectant, like household bleach.

Gloves – wear latex, vinyl or rubber disposable gloves when handling blood, body fluids, or when cleaning cuts, scrapes or wounds. Wash hands after removing gloves, and dispose of the gloves in a plastic bag. Add gloves to your first aid kit so they are always ready. They are not expensive, and can be bought at any drugstore.

Needlestick injuries – go to the nearest Health Unit or hospital emergency department immediately for treatment assessment.

Sharp objects – place needles and syringes in a safe container. **NEVER re-cap, bend or break off used needles!** Place them in a puncture-proof metal or plastic container with a lid, such as an empty coffee tin and then place in the garbage.

Personal articles – never share toothbrushes or razors. They can transmit small amounts of blood from one user to the next. Dispose of razors carefully. Wrap sanitary napkins before disposing. Handle bloody bedding or clothing cautiously, and wash in hot soapy water.

Handwashing is the best single way to prevent the spread of germs from one person to another. Wash hands thoroughly with *soap and water* for at least 15 to 20 seconds.

Always wash hands:

- before preparing food
- before mealtimes
- before breastfeeding, and
- after toiletting or diapering
- before and after providing first aid
- after handling blood or body fluids

Cover your mouth when you cough or sneeze, then wash your hands. Don't pass *your* germs on to others.

Teach others – particularly children about healthy behaviour and potential risks and how to deal with them safely.

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How can you keep yourself safe?

Blood splashed on your skin may cause infection by getting into cuts, nicks, or raw chapped areas. Protect yourself by wearing gloves if you are going to be exposed to blood or other body fluids. For example, if you help someone who has a bleeding nose you should wear vinyl or latex disposable gloves to protect your skin. If this is not possible, continue to help the person and then wash immediately afterwards.

Gloves are not necessarily required if you come into contact with urine, feces, nasal secretions, saliva or vomit, **UNLESS** you can see blood in it. However, in some situations you may prefer to wear gloves. **Remember, it is always important to wash your hands carefully after touching any body fluids, even if you have worn gloves.**

How can you safely clean up spills of blood or other body fluids?

1. Protect yourself by wearing disposable vinyl or latex or rubber gloves. If there is a risk of splashing use protective eye wear.
2. Use disposable absorbant material such as paper towels to remove most of the spill. Place these in a plastic bag and deposit in the garbage.
3. Wipe the floor, or any contaminated surfaces with a disinfectant solution. This can be easily made by mixing one part household bleach to ten parts of water. This type of bleach solution should be freshly made up or it may loose its strength. For carpets or upholstery that may be damaged by bleach, other household germicides or disinfectant agents can be used. Soak mops or brushes that have been used for cleaning in a disinfectant for 20 minutes.
4. When you are finished wash your hands thoroughly with soap and water.

What should you do if you find a used syringe or condom?

A needle that someone else has used contains a small amount of their blood which may carry the AIDS or hepatitis B virus. Used condoms can also contain infectious body fluids.

Teach children **NEVER** to touch needles, syringes or condoms, and to tell an adult about them immediately.

If you find a used syringe or condom – especially in a park, school or play ground – it is important to dispose of them promptly and carefully.

1. Use a pair of tongs or pliers, or a pair of sturdy gloves to pick up these items.
2. Discard condoms in a plastic bag.
3. Discard syringes or needles in a puncture-proof container, preferably one intended for such purposes. Any plastic or metal container with a lid, such as a coffee can, will also do.
4. When you have finished wash your hands carefully with soap and water.

While the risk of infection from used condoms and syringes is very low, it is best to limit this risk as much as possible. It is important to help children understand how important these necessary precautions are.

What should you do if you accidentally prick yourself with a dirty needle?

- If possible, put the pricked area low to the ground to promote bleeding.
- Wash the area well with soap and water.
- Go to your nearest local health unit or hospital Emergency Department immediately for treatment assessment.

REMEMBER - ALL BLOOD AND BODY FLUIDS ARE POTENTIALLY INFECTIOUS.

For further information contact your local public health nurse or your family doctor.

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What are the Health Files? . 6-8

The Health Files are a series of one page, easy-to-understand fact sheets about a wide range of public and environmental health and safety issues, produced by the Ministry of Health.

The program is managed from Victoria, and consists of a three-ring binder, carried in each of the province's 120+ health units and departments and certain other offices (i.e., Government Employee Health Services, Native Health Centres and Nursing Stations). The binder has both an alphabetical crossindex and numeric index for easy reference, making it easy for field staff to locate and use specific Health Files as needed.

What do the Health Files talk about?

One of their major functions is to provide basic "informed consent" information (i.e., descriptions of symptoms, prevention, possible vaccine reactions, contra-indications) to parents of children who go through the provincial childhood immunization regimen.

Health Files also deal with a wide range of other health subjects. They provide information about many childhood and adult diseases; environmental health hazards; problems with pests; maintaining septic systems; infant dental care; childhood vision problems and how to protect yourself from communicable diseases in work settings. They also give advice to travelers on precautions to take while abroad, safety tips around swimming pools and how to avoid food poisoning.

Internet access

Health Files are available to the general public on the Internet, on the Ministry of Health's home page (http://www.hlth.gov.bc.ca) under "General Health Information."

Recorded Health Files

Recorded versions of some of the Health Files (Chickenpox, Head Lice, Hepatitis B & C, Giardiasis, Lyme Disease, Scabies, Hantavirus, and Water-borne disease) are now available to the public over the Ministry of Health Information Line (toll free within British Columbia, 1-800-665-4347 or 952-1742 in the Greater Victoria area).

STANDARD E.2 Safety and Emergency Practices

Children receive care that promote their safety and well-being.

Commentary

The safety and well-being of children are the paramount considerations under *the Child, Family and Community Service Act*. It is the responsibility of the caregiver and the child's social worker to take all reasonable steps to reduce the level of risk that a child may be exposed to the physical environment of the foster home. This is a fundamental requirement for the healthy development of the child.

Results for Children

E.2.1. Children confirm that they know what to do and how to escape in the event of a fire or other emergency.

E.2.2. Children confirm that they know what to do if they think something in the home or its surroundings is unsafe and confirm that any concerns have been, or would be, addressed satisfactorily.

E.2.3. Children confirm that they have been advised of known hazards in the physical environment of the foster home.

Caregiver Practices

E.2.4. The caregiver posts and ensures the child is aware of the current household emergency response plan for fires, earthquakes, disasters and other emergencies.

E.2.5. The caregiver ensures that the household emergency response plan takes into consideration individuals who require assistance.

E.2.6. The caregiver ensures that the household emergency response plan is practiced at least every six months and immediately following the placement of a child in the home.

E.2.7. The caregiver advises the child of known hazards in the physical environment of the foster home.

E.2.8. The caregiver ensures the child is supervised when in an area of the physical environment of the foster home containing known hazards.

E.2.9. The home has at least two exits from each floor commonly used by household members as living or recreation space. Doorways, exits, ramps and stairs are kept unobstructed and readily accessible for exit.

E.2.10 Each room commonly used for sleeping has at least one opening window equipped for emergency exit.

E.2.11. The home has at least one functioning smoke detector or alarm approved by the Underwriter's Laboratories of Canada, mounted on or near the ceiling in the corridor of each sleeping area and on each floor. The detector(s) or alarm(s) are tested at least once per month. Batteries are changed at least once per year.

E.2.12. The home has at least one five-pound ABC fire extinguisher readily accessible to the kitchen. Fire extinguishers are tested once per year to ensure that they are fully charged and operable.

E.2.13. There is a working telephone or other means of ensuring reliable and regular communication with others outside of the home.

E.2.14. Emergency telephone numbers, including fire, police, doctor, ambulance and poison control, are clearly written and readily available by the telephone. If the home does not have a telephone, then clearly written instructions are readily available regarding how to ask for help outside of the home in an emergency.

E.2.15. Heat, light, and ventilation are adequate for safe and comfortable occupancy.

E.2.16. Heating systems including oil and gas furnaces, wood burning stoves, and fireplaces as well as electrical systems are properly installed and maintained.

E.2.17 The home has a well-maintained first-aid kit which is readily accessible to household members. Any restriction on accessibility will reflect consideration for the child's level of development and specific safety concerns as outlined in the comprehensive plan of care.

E.2.18. All poisonous substances and medications are clearly labeled and stored in a locked location. Access by the child is based on consideration of their developmental level and on any specific safety concerns as outlined in the child's comprehensive plan of care.

E.2.19. All poisonous and hazardous materials, objects and equipment are securely stored. Specific methods of storage are based on consideration of the child's developmental level or on any specific safety concerns as outlined in the child's comprehensive plan of care.

E.2.20 All weapons are inaccessible to children, and are disassembled or made otherwise unusable.

E.2.21 All firearms are stored in accordance with federal legislation and Department of Justice regulations, including the following requirements:

a) the firearm is unloaded;
b) the firearm is rendered inoperable by removing the bolt or installing a trigger lock; and
c) ammunition and firing mechanisms are stored separately from the firearm in securely locked container or cabinets.

E.2.22 Dogs, cats and other domestic animals maintained on the premises are kept in a safe and sanitary manner and according to provincial and local requirements. Dogs and cats maintained on the premises have up-to-date rabies vaccinations. Children are protected from animals which are potentially dangerous to them.

E.2.23 Outdoor play or recreation areas which are part of the physical environment of the foster home are safe and comply with any legislation and local by-laws and the following requirements:

a) play and recreational equipment are age appropriate, in good working condition and structurally sound;
b) all in-ground pools are enclosed with safety fences;
c) swimming pools are regularly tested to ensure the pool is free from contamination.

E.2.24 The caregiver ensures that the children are supervised at all times by a responsible adult while using swimming pools or trampolines.

E.2.25. The caregiver ensures that all vehicles used to transport children:

a) meet *Motor Vehicle Act* requirements;
b) are maintained in safe condition;
c) include age appropriate, certified child restraint systems;
d) have adequate insurance necessary to carry out the caregiver's responsibilities, including motor vehicle third-party legal liability insurance coverage of at least one million dollars; and
e) are operated in a safe manner by a person with a valid driver's license of the appropriate classification.

E.2.26. When a child is transported in a motor vehicle, the caregiver ensures that the child is properly secured in a certified restraint system, in accordance with the *Motor Vehicle Act Regulations* and the *Canadian Motor Vehicle Safety Standards*. In addition, and whenever possible, the caregiver ensures that children twelve years of age and under are seated in the back seat.

Source: *Standards for Foster Homes* © 1998, Ministry for Children and Families

The Child's Service Records 6-10

STANDARD F.2 Child's Individual Service Records

Children have accurate, individual, secure and confidential records of their relevant history and progress in the home.

Commentary

The child's individual service record contains information of a sensitive and highly personal nature about the child and possibly their family. The caregiver ensures the information is accurate and protected from unauthorized access. The child's individual service record is subject to legislation governing the protection of privacy and freedom of information, including the *Child, Family and Community Service Act* and the *Freedom of Information and Protection of Privacy Act.* While the child's individual service record is maintained by the caregiver as part of their contractual obligations, the record is the property of the director responsible for the child. The child is entitled to access the record according to procedures in the relevant legislation and policy. The child's individual service record is an important part of the child's history.

Results for Children

F.2.1 Children confirm that, to the best of their knowledge, the caregiver maintains an individualized service record about them.

F.2.2 Children confirm that, to the best of their knowledge, their individual service records are stored securely.

F.2.3 Children are provided support in gaining access to their records in accordance with procedures identified in legislation, including the *Freedom of Information and Protection of Privacy Act* and the *Child, Family and Community Service Act,* and policy of the Ministry for Children and Families.

Caregiver Practices

F.2.4 The caregiver keeps a separate individual service record for each child placed in the home.

F.2.5 The caregiver keeps all information and documentation pertaining to the child in the child's individual service record, including:

a) intake information and documentation;
b) legal documents;
c) medical and dental information;
d) signed consent forms;
e) assessment information;
f) caregiver's current responsibilities under the child's comprehensive plan of care, and related reviews and reports;
g) a day book for the child that includes information regarding the child's normal daily routines, both current and recent past;
h) information regarding complaints made by the child;
i) documentation of reportable incidents involving the child;
j) documentation of service termination; and
k) other information and evaluations required to deliver and monitor services provided to the child.

F.2.6 The caregiver maintains and stores the child's individual service record in accordance with relevant sections of the *Freedom of Information and Protection of Privacy Act,* the *Child, Family and Community Service Act* and records management procedures of the Ministry for Children and Families. This confidential record is kept in a locked location.

F.2.7 The caregiver provides support to the child in gaining access to their individual service record in accordance with the procedures described in legislation, including the *Freedom of Information and Protection of Privacy Act* and the *Child, Family and Community Service Act,* and Ministry for Children and Families policy.

F.2.8 The caregiver does not permit the destruction of the child's individual service record.

F.2.9 The caregiver gives a director access to the child's individual service record upon request.

Source: *Standards for Foster Homes* © 1998, Ministry for Children and Families

Rights of Foster Families 6-11

Foster families are entitled to the same rights as all Canadian citizens under the *Canadian Charter of Rights and Freedoms,* and provincial/territorial legislation.

To help ensure that children in care receive the best possible care foster parents are entitled to:

- be treated with consideration, trust, honesty, respect, acceptance and fairness by the director
- receive pertinent information for the care of the child, including, but not limited to, medical, education, personal care information, significant family personal history as well as care, guardianship, custody and access arrangements
- receive a clear understanding of their roles as caregivers and the roles of the director
- refuse to provide care for a child if they feel they cannot meet the child's needs
- participate in decision-making regarding a child in care and to be treated as a member of the team in developing the child's Plan of Care
- receive support from and be able to consult with the director so as to better meet the needs of children in care
- be notified of any court action or third-party review regarding a child in their care
- be informed of any dispute resolution processes available when they have a disagreement with the director
- be provided with reasons when a child in care is removed from them
- be provided with reasons when a home or resource is to be closed

Foster parents in Family Care Homes are also entitled to:

- be trained in their roles as members of a child's care team and be provided with educational opportunities with respect to caring for children
- receive services to support and stabilize the placement
- participate in foster parent training and local Foster Parent Associations
- access information about themselves kept in the director's records
- appeal a termination or suspension of their agreement
- be provided with access to support services when placements are terminated to minimize the caregivers' feelings of disruption or grief
- be considered as a permanent family for a child, along with all other suitable homes, if the director determines that a permanent plan is in the child's best interests

In working with foster parents, the director has the responsibility, as provided for in the caregivers' agreements, to:

- provide support, assistance and advice as may be needed, at a level consistent with available staff time and resources
- ensure through consultation that the needs of a child placed do not exceed the abilities and resources of the caregivers
- assist the foster parent, if requested, in accessing all available community services if a member of the foster family is physically or emotionally injured because of an assault by a child in care or a member of the child's family

Placement of Sara, Jason and Darren

This sibling group, 12, 10 and 4 years of age came into care by court order when the two older children called the Ministry for Children and Families from a shopping mall to say that there was a drunken and violent gathering at their apartment and that they were afraid to go home. By the time the police and a ministry worker got to the home the party had moved on and 4-year-old Darren was found home alone.

All 3 children were removed and placed together in a foster home. Sara and Jason had previously been in care several years ago following a serious traffic accident in which they were passengers in a car driven by their seriously impaired mother. The children had been returned to the mother following her release from hospital some weeks later.

Darren's father died of an overdose while his mother was pregnant with him. The family has lived a very unsettled life with frequent moves and heavy partying, much drinking and suspected IV (intravenous) drug use. Darren was born with Hepatitis C. In the foster home, Sara and Jason are surly and uncooperative, while Darren demands a lot of attention, is unable to share anything with other children in the home, and is easily moved to tears.

Questions for Sub-Group Discussion:

Activity 3 – What Can We Do to Help?

Recognizing that coming into care is a transition process that requires a sensitive response on the part of the foster family, what are the child's needs in this situation, and what might be effective ways for the foster family members to respond?

Activity 4 – What Resources Might be Helpful?

a) What resources might be helpful for each of the children?

b) What resources might be helpful for the foster family members themselves?

Placement of Mosha

Mosha is a 15 year old girl who came into care by court order when the school reported that she was being stalked by a relative and that this followed a pattern of escalating conflicts with her parents. The fights involved pushing, shoving, hair pulling, slapping and intense emotional abuse by way of frequent insults, put-downs and verbal abuse.

Mosha's parents and three sisters emigrated from the Middle East four years ago in the hope of a better life and improved education for the children. The parents appear to care about their children a great deal but adjustment difficulties in Canada have resulted in increasingly violent relationships within the family.

The parents' belief system cannot allow their daughters freedom to spend time with friends of their choice, particularly boys, to wear make-up, to attend Western movies and to adopt the corrupt ways of Western culture. Mosha's father has attempted to control all the girls' activities. After being threatened with a knife, Mosha's eldest sister recently moved away and the father responded by hiring his unemployed brother-in-law to follow the other girls when they went out.

Over the past 18 months, Mosha has attempted suicide several times by taking various drugs. In the foster home she appears very depressed and refuses to go to school.

Questions for Sub-Group Discussion:

Activity 3 – What Can We Do to Help?

Recognizing that coming into care is a transition process that requires a sensitive response on the part of the foster family, what are the needs that are apparent in this situation, and what might be effective ways for the foster family members to behave?

Activity 4 – What Resources Might be Helpful?

a) What resources might be helpful for Mosha?

b) What resources might be helpful for the foster family members themselves?

Placement of Nathan

Nathan is a ten-year-old aboriginal boy who came into care after he served a two-month sentence in the Youth Custody Centre for being involved in a series of break and enters with a 16-year-old boy. His mother lives off reserve, and she does not know what to do to help her son to stay out of trouble.

Nathan's mother has recently been diagnosed with cancer, and is receiving intense chemotherapy. Nathan's father left his wife just before the diagnosis and is living in Alberta with a 19-year-old girl who used to babysit for the family.

Nathan is very angry with his father for abandoning him, and he also resents his mother being so ill and unable to care for him. He says that he wants to be a professional thief because that is the only way he will ever be able to support himself. He refuses to go to school, as he says the other students make fun of him and bully him.

Questions for Sub-Group Discussion:

Activity 3 – What Can We Do to Help?

Recognizing that coming into care is a transition process that requires a sensitive response on the part of the foster family, what are the needs that are apparent in this situation, and what might be effective ways for the foster family members to behave?

Activity 4 – What Resources Might be Helpful?

a) What resources might be helpful for Nathan?

b) What resources might be helpful for the foster family members themselves?

Evaluation of Module 6

In order to assist the facilitators in planning and structuring future training sessions, we welcome your comments and suggestions. This form should only take a few minutes to complete. Thank you.

Please rate how well the session helped you to attain the following objectives.

1. I think I have the information necessary to consider a placement into my home, should I decide to foster.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

2. I feel ready to respond to the initial stages of a child's experience coming into care.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

3. I am aware of the kinds of resources I could access for a foster child in the event of need.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

4. I am aware of sources of support for me and my family in the event of need.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

5. I am aware of the communication and reporting necessary to support the foster care process.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

6. I think that all of the questions I had about my readiness to foster have been addressed.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Comments?

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Overall Evaluation of Orientation

In order to assist the facilitators in planning and structuring future training programs, we welcome your comments and suggestions. This form should only take a few minutes to complete. Thank you.

Please rate the Orientation program on the following objectives.

1. The sessions were generally interesting and engaging of my interest.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

2. The sessions were worthwhile in helping me to understand foster care in B.C.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

3. The range of topics and activities were generally appropriate to my needs.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

4. I am better prepared to make my decision about fostering.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

5. I believe that these sessions meet the objectives they are designed to achieve.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

6. I felt respected and acknowledged in the sessions.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Comments? (Use the back of the sheet if necessary)

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